**REQUEST FOR MEDICAL/DENTAL RECORDS OR INFORMATION**

**REQUESTING ACTIVITY**
- Complete Items 1 through 10 (Except 8b); also complete Item 19.
- Complete Items 8a, 11 to 14 or 15 to 18, as appropriate.

**ADDRESSEE**
- Complete Items 8a, 11 to 14 or 15 to 18, as appropriate.
- Final referral shall return to requester.

1. **PATIENT**
   - (Last Name - First Name - Middle Name)

2. **ORGANIZATION AND PLACE OF TREATMENT**

3. **STATUS**
   - X MILITARY
   - VA BENEFICIARY
   - DEPENDENT
   - FEDERAL EMPLOYEE
   - OTHER (Specify)

4. **TO**
   - (Include ZIP Code)

   **PRESIDIO OF MONTEREY (POM)**
   **U.S. ARMY HEALTH CLINIC**
   **473 CARRILLO ST, BLDG# 422**
   **PRESIDIO OF MONTEREY, CA 93944**
   **831-242-7550**

5. **IDENTIFYING INFORMATION**
   - a. SERVICE NUMBER
   - b. GRADE/RANK
   - c. SOCIAL SECURITY ACCOUNT NO.
   - d. VA CLAIM NUMBER
   - e. DATE OF BIRTH (If Federal employee)

6. **DATES OF TREATMENT**
   - (Inclusive)

7. **DISEASE OR INJURY**

8. a. **RECORDS REQUESTED**
   - ML VA
   - CLINICAL
   - OUTPATIENT HEALTH RECORD
   - DENTAL RECORD
   - X-RAY
   - MEDICAL REPORT CARDS, EMERGENCY MEDICAL TAGS, FIELD MEDICAL CARDS
   - ABSTRACT OF RATING SHEET
   - REPORT OF PHYSICAL EXAMINATION
   - ALL AVAILABLE RECORDS (Except x-rays unless specifically requested)
   - OTHERS (List under remarks)

9. **REMARKS**

10. **SIGNATURE**

11. **TO:**

12. **REMARKS**
   - RECORDS CHECKED IN 8b: FORWARDED.
   - NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD.
   - MORE INFORMATION NEEDED. FURNISH FOLLOWING:

REPLY/REFERRAL

13. **SIGNATURE**

14. **DATE**

REPLY/SECOND REFERRAL

15. **TO:**

16. **REMARKS**
   - RECORDS CHECKED IN 8b: FORWARDED.
   - NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD.
   - MORE INFORMATION NEEDED. FURNISH FOLLOWING:

17. **SIGNATURE**

18. **DATE**

19. **RETURN TO:**
   - (Include ZIP Code)

**DD FORM 877, SEP 67**

REPLACES EDITION OF 1 JAN. 60.

WHICH MAY BE USED.

REQUESTING ACTIVITY WILL ENTER COMPLETE ADDRESS TO WHICH RECORDS OR FINAL REPLY SHOULD BE MAILED.
MEDICAL RECORDS by filling out a DD-877 form, this is very important. If you do not request them they will not be sent to your new duty station. The form need to be faxed to:

U.S. Army Health Clinic
ATTN: Outpatient Medical Records
473 Cabrillo Street Suite A1A
Monterey, CA 93944
Phone: (831) 242-3410 Fax: (831) 242-6745

Also make sure to update your new duty station on the TRICARE website.