



Department of Veterans Affairs

**MEDICAL CERTIFICATE**

1. DATE	2. TIME <input type="checkbox"/> AM <input type="checkbox"/> PM	3. AGE	4. SEX <input type="checkbox"/> M <input type="checkbox"/> F	5. ON ARRIVAL PATIENT WAS: <input type="checkbox"/> AMBULATORY <input type="checkbox"/> STRETCHER <input type="checkbox"/> WHEELCHAIR			6. PHONE NUMBER	7. HOMELESS <input type="checkbox"/> YES <input type="checkbox"/> NO
8A. ALLERGIES			8B. WEIGHT	8C. TEMPERATURE	8D. PULSE	8E. RESPIRATION	8F. B/P	8G. DUE TO INJURY <input type="checkbox"/> NO <input type="checkbox"/> YES

**9. CURRENT MEDICATIONS**

**10. TRIAGE**

11. SIGNATURE

**12. HISTORY AND PHYSICAL**

**13. DIAGNOSTIC IMPRESSIONS**

**14. PLAN**

15A. ATTENDING OF RECORD

15B. EXAMINER'S SIGNATURE

**SECTION II - FOR PATIENT**

1. DISPOSITION/CLINIC APPOINTMENT	2. AFTER CARE SHEET GIVEN <input type="checkbox"/> YES <input type="checkbox"/> NO	3. FOLLOW UP - ACTIVITY - LIMITATIONS
4. CONDITION <input type="checkbox"/> IMPROVED <input type="checkbox"/> SATISFACTORY <input type="checkbox"/> UNCHANGED	5. DATE/TIME OF DISCHARGE	6. SIGNATURE TO INDICATE INSTRUCTIONS GIVEN

IMPRINT PATIENT DATA CARD

7. PATIENT INSTRUCTIONS

**I CERTIFY THAT I RECEIVED AND UNDERSTAND THESE INSTRUCTIONS**

8. PATIENT'S SIGNATURE



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