☐ AUTHORITY FOR INPATIENT ADMISSION (ESTIMATED LENGTH OF STAY: MORE THAN 24HRS
☐ AMBULATORY PATIENT VISIT (APV) (ESTIMATED LENGTH OF STAY LESS THAN 24HR

AUTHORITY FOR ADMISSION

NAVAL MEDICAL CENTER – SAN DIEGO, CA

Please Print

PART I: TO BE COMPLETED BY ADMITTING PHYSICIAN				
ADMIT TO WARD:	ROOM NO.:	**(Check one)** ☐ ERA ☐ ROUTINE ☐ URGENT	ADMISSION DATE:	REGISTER NUMBER:
TYPED BY:	REVIEWED BY:	ADMISSION TIME:		
PROFESSIONAL SERVICES:	STAFF PHYSICIAN NAME: (Please Print)	STAFF PHYSICIAN SIGNATURE:		

INPATIENT MEPRS CODES (CIRCLE ONE)					
AABA	CARDIOLOGY	ADBA	NURSERY	ADAA	PEDIATRICS
ABBA	CARDIOVASCULAR/THORACIC SURGERY	ACBA	OBSTETRICS/GYNECOLOGY	AFAA	PSYCHIATRY
ABAA	GEN SURGERY/PERIPH VASC/PEDIATRIC SURGERY	ABFA	ORAL SURGERY	ABKA	UROLOGY
AAAA	INTERNAL MEDICINE	AEAA	ORTHOPEDICS/HAND/PODIATRY		
ABDA	NEUROSURGERY	ABGA	OTOLARYNGOLOGY		

DIAGNOSIS ONE:		ICD9:
SCHEDULED PROCEDURE # 1:		CPT 1:
SCHEDULED PROCEDURE # 2:		CPT 2:

PART II PATIENT INFORMATION					
LAST NAME:	FIRST NAME:	MIDDLE NAME:			
HOME ADDRESS:	APT/CONDOMINIUM NO:	PATIENT'S SSN:			
CITY:	STATE:	ZIP CODE:	RACE:	ETHNIC ORIGIN:	RELIGION:
HOME PHONE #: ( )	CELLULAR #: ( )	WORK PHONE: ( )			
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED	IF FAMILY MEMBER IS A CHILD, IDENTIFICATION ON DEERS: __________				
CATEGORY: ☐ ACDU ☐ FAMILY MBR (ACDU) ☐ FAMILY MBR (ACDU DECEASED) ☐ RETIRED ☐ FAMILY MBR (RET) ☐ FAMILY MBR (RET DECEASED) ☐ OTHER________________					
IF BEING ADMITTED FOR CHILD DELIVERY WHAT NUMBER OF CHILD WILL THIS BE :____________ EDD:____________					

DEERS INFORMATION CHECKED BY PAD Representative				
ID CARD NUMBER (Minor without ID CARD, use sponsor's number)	EXPIRATION DATE:	ELIGIBILITY:	DOB:	SEX:
Name of PAD Representative (Please Print):	Signature of PAD Representative:	Date:		

Please Print

PART III SPONSOR INFORMATION (IF YOU ARE ACDU OR RETIRED – YOU ARE YOUR OWN SPONSOR)					
SPONSOR LAST NAME:		FIRST NAME:		MIDDLE NAME:	
DoD ID:	RATE/RANK:	DESIG/MOS/AFSC:	TIME IN SERVICE: (DAYS,MONTHS OR YRS)	FLY: (CIRCLE ONE) Y N	BRANCH OF SERVICE:
LOCAL UIC:	NAME OF COMMAND:				
DUTY STATION PHONE NUMBER: ( )	IS ACDU MILITARY SPONSOR: ☐ STAFF ☐ STUDENT ☐ INSTRUCTOR				

PART IV EMERGENCY CONTACT INFORMATION FOR PATIENT		
NAME: (Last Name, First Name, Middle)		RELATION:
ADDRESS: ☐ Same as Patient		HOME/CEL: ( )
CITY:	STATE:	ZIP CODE:

PART V NEXT OF KIN INFORMATION FOR PATIENT		
NAME: (Last Name, First Name, Middle)		RELATION:
ADDRESS: ☐ Same as Patient		HOME/CEL: ( )
CITY:	STATE:	ZIP CODE:

PART VI ACCIDENT/INJURY INFORMATION	
IF INJURED WERE YOU: ☐ ON DUTY ☐ OFF DUTY ☐ OTHER THAN ACTIVE DUTY MEMBER	
PLEASE EXPLAIN:	TIME AND DATE OF ACCIDENT:
IF MOTOR VEHICLE ACCIDENT, WERE YOU ☐ DRIVER ☐ PASSENGER ?	WERE YOU TRANSFERED FROM ANOTHER HOSPITAL? ☐ Y ☐ N
ORIGINAL ADMISSION DATE AND TIME:	NAME OF TRANSFERRING HOSPITAL:

TITLE 18 USC, SECTION 1001. Statements or entries generally:

Whoever, in matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representation or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry shall be fined not more than $10,000 or imprisoned not more than five years, or both.

I HAVE READ AND UNDERSTAND; SECTION 1001 TITLE 18 USC, QUOTED ABOVE AND I CERTIFY UNDER PENALTY OF LAW THAT ALL INFORMATION ON THIS FORM IS TRUE, ACCURATE, AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE:	DATE: