N14 SSO Medical RHRP QTC

IMR Service Request Form

Name (Last, First, MI): _____

DOD-ID: _____

Email (must have access): _____

Phone Number: _____

Address (Street, City, State, Zip Code): _____

Services Requesting

(Check the Box or Highlight)

- ☐ Audiogram
- ☐ Dental Exam
- ☐ Dental X-Rays
- ☐ Eye Exam
- ☐ Immunization – Hep A
- ☐ Immunization – Hep B
- ☐ Immunization – MMR
- ☐ Immunization – Polio
- ☐ Immunization – TDap
- ☐ Immunization – Twin Rix
- ☐ Venipuncture – DNA Testing
- ☐ Venipuncture – G6PD
- ☐ Venipuncture – HIV
- ☐ Venipuncture – Sickle Cell
- ☐ PDHRA
- ☐ PHA
- ☐ Pre-DHA