DR. WALTER O. MOSS REGIONAL MEDICAL CENTER
1000 WALTERS ST LAKE CHARLES, LA 70607

Pt Name: Age: DOB: / /
MR#: SSN: - - Race: Sex: Mar Sts: Religion:
Pt#: Nrs Sta: Rm/Bed: Pt. Type: HspSvc: FC:
Address: Parish:
City: St: Zip: Phone: ( ) -
Emg Contact: Pt Rel: Phone: ( ) -
Medicare#: Type: Medicaid#:

Admit Date/Time: _____ /_____ /_____ : Provisional DX:
Admit Dr: -
Attnd Dr: -

Discharge Date: _____/_____/_____ Number of Hospital Days: _____
Discharge: __Normal __Desertion __Transferred __Died Autopsy: __Yes __No
PCP: AUTH: MRSA: VRE:
INFORMED OF AV DIR: AV DIR IN CHART: VISIT RESTRICTIONS:

FINAL DIAGNOSIS (no abbreviations)	Code

DATE	Operative and Nonsurgical Procedure	Code

I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge.

_____ _____ _____ _____

Intern/Resident Date/Time Attending Staff Date/Time