PATIENT NAME:
MRD NO: SEX :
DOB : Tel No:

CONSULTATION / PROCEDURE REFERRAL FORM

FROM (REFERRING DOCTOR).....

REFERRED TO..... **DATE**.....

TIME.....

TYPE OF REFERRAL: ☐ Internal Referral ☐ External Referral ☐ Procedure Referral

CATEGORY: ☐ Urgent ☐ Routine **REFERRAL AS** ☐ OPD ☐ In-Patient ☐ ICU

TYPE OF CONSULTATION ☐ Consultation Only ☐ Consultation with Directive Care ☐ Consultation with continuing care ☐ Transfer

PART A (To be filled by Most Responsible Physician)

REASON FOR REFERRAL AND CLINICAL DETAILS:

Kindly examine and advise. Thank you.
Stamp and signature of the Most Responsible Physician Date Time

PART B (CONSULTATION REPORT)

Stamp and signature of the Consulting Doctor Date Time

*DEFINITIONS
Consultation only: Consultant is asked to make an assessment and management suggestions.
Consultation with directive care: The consultant assists with the ongoing care of the patient including appropriate orders and follow up. The consultant is not the most responsible physician.
Consultation with continuing care: Consultant takes over the entire care of the patient and becomes the Most Responsible Physician.