Appendix XIV

Two-Way Standard Medical Consult Request Form

Date: ___ ___/ ___ ___/ ___ ___ Hospital Number _____

First Name: Middle Name Surname

Referring Consultant/Clinic/Ward/Unit: To:

Age: _____ Male ☐ Female ☐ LMP: Parity: Occupation:

Reason for the Referral:

1. *Consultant Opinion Request (Not a transfer): ☐ 2. *Co-Management Request (Not a transfer): ☐
3. Taking Over Management (A transfer of care): ☐ * A feedback is appreciated. Thank you.

Principal Symptoms (with duration):

Associated Symptoms:

Relevant Concomitant Medical History: Hypertension ☐ Diabetes ☐ Hyperlipidaemia ☐ Depression ☐
Schizophrenia ☐ Thyroid Disease ☐ Cancer ☐ HIV ☐ SCD ☐ Seizure Disorder ☐
Others:

Past Medical History (including previous hospitalisation etc.): ☐ None

Past Surgical History: None ☐

Relevant Psycho-Social History: None ☐

Current Medication List:

Allergies: No ☐ Yes ☐ **Allergy to:**

Relevant Clinical Findings:

Results of Relevant Investigations to Date:

Outline of Management to Date:

Provisional /Clinical Diagnosis:

Name of Referring Doctor: | **Signature**

Response Slip

Date: ___ ___/ ___ ___/ ___ ___ Hospital Number _____

First Name: Middle Name Surname

Referring Consultant/Clinic/War/Unit: To:

Clinical Diagnosis: Management Plan:

Signature: Thank you for the consult

Please Return Response Slip to the Referring Consultant through the Patient