

To:

Clinic Administrator
[Clinic Name]
[Clinic Address]
[Email / Fax / Secure Messaging Address]

From:

Dr. GP PR
General Practitioner
[Your Practice Name]
[Practice Address]
Phone: N/A
Email: vekovab239@boxmach.com
NZMC Registration Number: [Your Reg. No.]

Date: 26/06/2025

Patient Referral – Request for Appointment**Patient Details:**

Full Name: Jose M
Date of Birth: [DD/MM/YYYY]
NHI Number: [NHI-XXX]
Gender: Male
Address: [Patient Address]
Phone Number: 45895653265
Email: jose123@gmail.com

Referral To:

[Specialist / Department Name]
[Receiving Clinic Name]
[Preferred Clinician (if any): Optional]

Reason for Referral:

hbfvfuubjug

Clinical Summary:

Relevant history: [Brief clinical history]
Examination findings: [Key findings]
Investigations performed: [Bloods, Imaging, etc.]