Gilead Medical & Dental Centre

REFERRAL SLIP

DATE dd / mm / yyyy TIME HOSP. NO

PATIENT'S NAME

AGE GENDER ☐ M ☐ F

TO DOCTOR OF

CLINICAL HISTORY

EXAMINATION FINDINGS

INVESTIGATIONS DONE SO FAR

DIAGNOSIS AND DIFFERENTIALS

CURRENT TREATMENT

REASON FOR REFERRAL (MAY INCLUDE REFERRAL LETTER)

☐ Opinion / Advise on the way forward ☐ Take over Management

REFERRING DOCTOR

SIGNATURE

NOTE: PLEASE RETURN DUPLICATE TO MEDICAL RECORDS BEFORE DISPATCH