



## INITIAL MEDICAL ACCEPTANCE

**Patient Name:**

**Patient ID:**

**Referring Hospital:**

**Referral Date :**

The above patient is Accepted by Gama Hospital.

Kindly provide us with the following in order to finalize the acceptance:

- ☐ Copy of the ID
- ☒ Insurance approval
- ☐ Detailed Medical Report with investigations done.

**Kindly note:**

**You must receive the “final acceptance” before patient’s transfer.**

Contact number :

