



FINAL MEDICAL ACCEPTANCE

Patient Name:

Patient ID:

Referring Hospital:

Referral Date:

The above patient is **Finally Accepted** under the care of:

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:

The bed is available for only 24 hrs.

The patient must be fit for transfer.

Contact number:

