PANEL CLINIC REFERRAL LETTER

FOR SPECIALIST CLINIC OR HOSPITAL

From	**To**
Dr ________	Dr ________
Panel Klinik Name ________	Name of Hospital ________
Address ________	Address ________
________	________
Tel No: ________ email id ________	Tel No: ________ email id ________

Dear Dr,

Re: Patient Name ________ NRIC ________ Age ____ yrs ☐M ☐F

Provisional Diagnosis ________ Differential Diagnosis ________

Thank you for seeing the above patient with the following:

Chief Complaint ________

____

Findings (Please ✓ the appropriate box and answer ALL the questions or NA where not applicable)

Pulse ____ per min ☐Regular ☐ Irregular **BP** ____/____ **Temp** ____ **Looks Toxic** ☐ No ☐ Yes

Dehydration ☐ Yes ☐ No **Gait** ☐Normal ☐ Limping ☐ Unable to Walk **Gen Weakness** ☐ No ☐ Yes

CVS ☐Normal ☐ Abnormal ________ CCF ☐ Absent ☐Present

Lungs ☐Normal ☐ Abnormal ________

Liver ☐Normal ☐ Enlarged ____ cm **Spleen** ☐Normal ☐ Enlarged ____ cm

Kidneys ☐Normal ☐ Enlarged **Loin Tenderness** ☐Absent ☐ Mild ☐ Severe

Abd Tenderness ☐ No ☐ Mild ☐ Severe **RIF Tenderness** ☐Absent ☐ Mild ☐ Severe

Other relevant signs findings are ________

Investigations: Urine FEME ________ RBS Glucostix ____ mmol/L Platelet Count ________

Other specific findings ________

Past History of Illnesses **(with the date of commencement)**

Diabetes	☐No ☐ Yes Since ________	Pregnancy Related ☐No ☐Yes Since ________
Hypertension	☐No ☐Yes Since ________	Stroke/Isch Heart Disease ☐No ☐Yes Since ________
Cancer /Tumour	☐No ☐Yes Since ________	Congenital/Hereditary /Other ☐No ☐Yes Since ________
Psychiatric Illness	☐No ☐Yes Since ________	STD/HIV Related ☐No ☐Yes Since ________

Treatment is with the following medications: ________

____

This patient is referred for:

☐ Specialist Out-Patient Treatment ☐ Admission for Elective Treatment/Surgery

☐ 2nd Opinion & Investigation/ Physiotherapy ☐ Urgent Admission and Treatment

Kindly reply this referral with your findings and status of the patient. Your cooperation is much appreciated to refer the patient back to me for follow up treatment upon discharge.

With best wishes and Thank you,
Yours truly,

________ Dr. ________ CLINIC STAMP

Signature Name of Doctor

EMAS/2010/01/05 PRLS

Upon referral of all patients, non Panel Clinics too need to fax this duly filled form to 03 21610431

THIS FORM IS TO BE USED BY PANEL AND NON PANEL CLINICS