THE MILITARY HMO

DEFENCE HEALTH MAINTENANCE LTD

THE NATIONAL HEALTH INSURANCE SCHEME

REFERRAL FORM

NHIS ID No. .....

DATE_____

HMO CODE.....

FROM (HEALTH FACILITY) _____
REFERRED TO _____

SERVICE No. _____
PATIENT'S NAME_____
PATIENT'S RESIDENTIAL ADDRESS_____

PATIENT'S PHONE NUMBER(S) _____
CLINICAL FINDINGS _____
_____
_____

INVESTIGATION_____
_____
_____

PROVISIONAL DIAGNOSIS _____

REASON FOR REFERRAL _____

NAME OF REFERRING PERSONNEL_____

SIGNATURE & STAMP _____
DATE_____

.....

ACKNOWLEGEMENT SLIP

RECIEPIENT'S FACILITY _____

PATIENT'S NAME_____

NHIS ID No._____

ACTION TAKEN_____
_____

DOCTOR'S NAME & SIGNATURE_____