Referral Form
Dietetic Service

EASTERN COMMUNITY HEALTH CENTRE

EASTERN HEALTH ALLIANCE

For Appointment,

☐ Eastern CHC (Tampines)
Tel: 6782 6885 Fax: 6782 9591

PATIENT'S PARTICULARS (or affix patient's label)

Name: _____

NRIC: _____

Date of Birth: _____ Gender: F / M

Address: _____

_____ Contact No.: _____

Date of Appointment: _____

Time of Appointment: _____

PATIENT'S MEDICAL BACKGROUND

Height: _____ meters Weight _____ kilograms

Drug allergy: ◯ Yes ◯ No Specify: _____

Clinical Diagnosis: _____

_____

Existing Medical Conditions

	Year of Diagnosis		Year of Diagnosis
◯ Diabetes	( )	◯ Hyperlipidaemia	( )
◯ Hypertension	( )	◯ Others: _____	( )

HbA1c Results: _____ Date of last HbA1c test: _____

Fasting Blood Sugar: _____ Date of last Fasting Blood Sugar test: _____

DIETETIC SERVICE REQUEST (by appointment only)

◯ Diabetes ◯ Low Cholesterol ◯ Low Purine ◯ Low Salt

◯ Weight Reduction _____ kcal ◯ Others: _____

Referral Clinic (Clinic Stamp with tel and fax):

Name of Doctor: _____

MCR No.: _____

Signature: _____

Date: _____

Operating Hours (By appointment only)
Monday to Friday
8.30 am to 12.00 pm
1.00 pm to 5.00 pm

Eastern Community Health Centre (Tampines)
Our Tampines Hub
51 Tampines Avenue 4
#03-33 Singapore 529684