

Referral Form

PATIENT'S PARTICULARS

Name : _____
NRIC : _____ Date of Birth : _____ Gender : F / M
Address: _____
Contact No: _____ Date and Time of Appointment : _____

SERVICES REQUESTED (by appointment only)

- Digital Diabetic Retinal Photography (DDRP)
 Diabetic Foot Screening (DFS)
 Nurse Counselling & Education Services (NCE)
 Healthy lifestyle education Insulin therapy Medication education
 Podiatry
 Corns Calluses Thickened Nails
 Trimming of Ingrown Toenails (nail avulsion procedure is not available)

PATIENT'S MEDICAL BACKGROUND

Height : _____ m Weight : _____ kg
Drug allergy: Yes No Specify : _____
Existing Medical Conditions Date of diagnosis
 Diabetes / Type of insulin (if applicable) : _____
 Hyperlipidaemia _____
 Hypertension _____
 Others : _____
Date of last test
HbA1c : _____
Fasting Blood Sugar : _____
LDL: _____
TG: _____
Current Medicaton : _____

Referral Clinic (Clinic Stamp with tel and fax):

Name of Doctor : _____
MCR No : _____
Signature : _____
Date : _____