Specialist Referral Inter-Hospital Transfer Form

Referring Hospital

Receiving Hospital

Date

Patient Information

Full Name

Date of Birth

Gender

Select

Medical Record Number

Contact Number

Address

Clinical Details

Provisional Diagnosis

Clinical Summary

Investigations / Results

Treatment Given

Reason for Transfer

Specialist Referral Details

Name of Specialist

Specialty

Mode of Transfer

Escort Required

Select

Additional Notes

Referring Doctor's Name & Signature

Date & Time

Receiving Doctor's Name & Signature

Date & Time