|  |  |
| --- | --- |
|  | **CLINICAL SUPPORT SERVICES****HOSPITAL PENGAJAR UPM** |
| **REFFERRAL FORM OPHTHALMOLOGY CLINIC**  |

|  |  |
| --- | --- |
| NAME : |  REFERRING DEPARTMENT : |
| AGE: |  REFERRING DOCTOR:  |
| IC NUMBER /RN : |  DATE OF REFERRAL : |

Dear Doctor,

Thank you for seeing this patient. We are referring for pre-operative assessment.

|  |  |
| --- | --- |
| REASON FOR REFERRAL |  |
| DIAGNOSIS |  |
| OPERATION PLANNED |  |
| DATE OF OPERATION PLANNED |  |
| HISTORY |  |
| BP |  |
| HR |  |
| HEIGHT |  |
| WEIGHT  |  |
| PHYSICAL EXAMINATION |  |
| INVESTIGATION DONE  |  FBC RP ECG Blood Sugar LFT Echo  Others : Specify  |

Please kindly provide you expert opinion. Thank you.

Signature and official stamp

…………………………….