

# 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)

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 : \_\_\_\_\_