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

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| 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.

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| 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

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