REFERRAL FORM

*For Doctor's Use Only

Patient's Particulars (or affix patient's label)

Name: ____________________

NRIC No: ____________________ Gender: M / F

Appointment Date: __________ Appointment Time: __________

CHC Service Location: ____________________

Services (Please tick as required):

- ☐ Diabetic Retinal Photography
- ☐ Diabetic Foot Screening
- ☐ Nurse Counselling (Please tick counselling topics below):
  - ☐ Healthy Lifestyle
  - ☐ Medication Adherence
  - ☐ Insulin Administration
  - ☐ Home Monitoring (BP and blood glucose)

Medical Background

Lab Results	Date	Result	Unit
HbA1c			%
Fasting blood glucose (FPG)			mmol/L
Total cholesterol (TC)			mmol/L
HDL-cholesterol (HDL)			mmol/L
LDL-cholesterol (LDL)			mmol/L
Triglycerides (TG)			mmol/L

Current Medication: ____________________

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Referral Clinic Details (Clinic stamp, if any):

Name of Doctor: ____________________