

Hua Mei Mobile Clinic (HMMC)

Tel: 6593 9565 Fax: 6593 9566

Patient Referral form

Date of Referral: _____
Referral Source : Specify
Hospital/Department _____
Polyclinic _____
G.P. _____
Community Group _____
Family _____
Others _____

Referrer Information:

Name: _____

Relationship to patient: _____

Telephone number: _____

Aware of programme through: _____

Subsidy level as computed by Means Test

75% 50% 25% 0%

PATIENT INFORMATION:

Patient's Name :

Date of birth: _____ Male /Female

IC No. _____ Dialect: _____

Race: _____

Patient's Address :

Telephone number : _____ Is patient on PA? Yes /No

How can patient be contacted?

Contact person : _____ Contact Nos :

Relationship to patient: _____

Medical Data:

Medical Problems :

Current medical provider: (Be specific)

How does the patient currently get to the doctor? Include problems, if any.

Mobility Status:

Can get out of bed? Yes/No	With/ without assistance?
If no, for how long? _____	
Can walk within the home? Yes/No	With/ without assistance?
Can go to toilet? Yes/No	With/ without assistance?
Can walk outside of home? Yes/No	With/ without assistance?

Mental Status:

Confused? Yes/No Describe

Reason for referral:

Patient's Medication:
