



Bureau of Corrections

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RETURN SLIP

Page 1 of 1

Referring Institution:	Department:	Receiving Institution:	Date/ Time:	
Referring Physician:	Contact No:	Receiving Physician:	Contact No:	
Name:	Prison No:	Age:	Sex:	Civil : () Single () Married () Separated () Widower
Address:				
Current Working Diagnosis:				
Reason for Referral: () Consultation () Admission () Diagnostic Procedure () Per Patient's Request () Others				
Favorably Endorsed:				

Signature over Printed Name
Designation: _____

Printed Name & Signature of Referring Physician

RETURN SLIP

Date: _____

Name:	Prison No:	Age:	Sex:
Current Working Diagnosis:			
Action Taken:			

Printed Name & Signature of Receiving Physician

Contact Number: _____