| **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

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**RETURN SLIP** **Date:**

| **Name:** | **Prison No:** | **Age:** | **Sex:** |
|---|---|---|---|
| **Current Working Diagnosis:** | | | |
| **Action Taken:** | | | |

_____
Printed Name & Signature of Receiving Physician

Contact Number: _____