حكومة دبي
GOVERNMENT OF DUBAI

هيئة الصحة بدبي
DUBAI HEALTH AUTHORITY

Referral Form

original / copy

Referred by:	Name:			Position:		
School Name and Address:				Date of referral:		
Telephone arrangements made:	YES	NO	Facility Tel No.	Fax No.		
Referred to Facility Name and Address:						
Student Name						
Identity Number				Age:	Sex:	M / F
Student address						
Clinical history						
Findings						
Treatment given						
Reason for referral						
Documents accompanying referral						
Print name, sign & date	Name:	Signature:		Date:		

Note to receiving facility: On completion of student management please fill in and detach the referral back slip below and send with patient or send by fax or mail.

---✂---receiving facility - tear off when making back referral---✂---

Back referral from Facility Name		Tel No.	Fax No.
Reply from (person completing form)	Name:		Date:
	Position:	Specialty:	
To Initiating Facility: *(enter name and address)*			
Student Name			
Identity Number		Age:	Sex: M / F
Student address			
This student was seen by: *(give name and specialty)*			on date:
Patient history			
Special investigations and findings			
Diagnosis			
Treatment / operation			
Medication prescribed			
Please continue with: *(meds, Rx, follow-up, care)*			
Refer back to:			on date:
Print name, sign & date	Name:	Signature:	Date:

Policy & Procedure No	Effective Date	Revision Due date	Revision No	First Edition Date
DHA/PHCSS/PCS/004	13.10.2015	12.10.2018	0	13.10.2015