

**Notice:** Routine appointments will be given, unless the referring doctor calls the intended specialist, who can be contacted on the dedicated line at MDH as instructed.

## PATIENT DETAILS

ID Card No.	<input type="text"/>	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Name	<input type="text"/>								
Address	<input type="text"/>								
Telephone	<input type="text"/>				Mobile	<input type="text"/>			
Age	<input type="text"/>	yrs	DOB	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Gender	M	<input type="checkbox"/>	F	<input type="checkbox"/>					

## NEXT OF KIN

Name	<input type="text"/>								
Telephone	<input type="text"/>				Mobile	<input type="text"/>			

## REFERRED TO:

### Medicine:

Asthma Clinic	<input type="checkbox"/>
Cardiology	<input type="checkbox"/>
Chest Clinic	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>
Gastroenterology	<input type="checkbox"/>
General	<input type="checkbox"/>
Haematology	<input type="checkbox"/>
Infectious diseases	<input type="checkbox"/>
Lipid Clinic	<input type="checkbox"/>
Nephrology	<input type="checkbox"/>
Neurology	<input type="checkbox"/>
Rapid Access	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>
Rheumatology	<input type="checkbox"/>

### Surgery:

Audiology	<input type="checkbox"/>
Bariatric (weight loss)	<input type="checkbox"/>
Breast Clinic	<input type="checkbox"/>
Dizziness Clinic	<input type="checkbox"/>
E.N.T	<input type="checkbox"/>
Endocrine (surgery)	<input type="checkbox"/>
General Surgery	<input type="checkbox"/>
Hepatobiliary	<input type="checkbox"/>
Lower GI	<input type="checkbox"/>
Neurosurgery	<input type="checkbox"/>
Ophthalmology	<input type="checkbox"/>
Orthopaedics	<input type="checkbox"/>
Paediatric Surgery	<input type="checkbox"/>
Plastic Surgery	<input type="checkbox"/>
Upper GI	<input type="checkbox"/>
Urology	<input type="checkbox"/>
Vascular Surgery	<input type="checkbox"/>

### Other Specialities:

Chinese	<input type="checkbox"/>
Dental	<input type="checkbox"/>
Dermatology	<input type="checkbox"/>
Dietitian/ Nutrition	<input type="checkbox"/>
Genetics	<input type="checkbox"/>
Geriatrics	<input type="checkbox"/>
GU Clinic	<input type="checkbox"/>
Gynae	<input type="checkbox"/>
Obstetrics	<input type="checkbox"/>
Oncology	<input type="checkbox"/>
Paediatrics (0-16yrs)	<input type="checkbox"/>
Paediatrics Speciality	<input type="checkbox"/>
Pain Clinic	<input type="checkbox"/>
Psychiatric	<input type="checkbox"/>
Thalassaemia	<input type="checkbox"/>
Tissue Viability	<input type="checkbox"/>

### Primary HealthCare

A.C.C	<input type="checkbox"/>
M.C.C	<input type="checkbox"/>
Cardiology	<input type="checkbox"/>
Physiotherapy	<input type="checkbox"/>
Podiatry	<input type="checkbox"/>
Nutritionist	<input type="checkbox"/>
Dietician	<input type="checkbox"/>
Primary Eye Screening	<input type="checkbox"/>
Speech and Language	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>
ECG	<input type="checkbox"/>
Orthopaedic	<input type="checkbox"/>
Immunisation	<input type="checkbox"/>
Gynae	<input type="checkbox"/>
GP appointment clinic	<input type="checkbox"/>
Scoliosis	<input type="checkbox"/>
ADSC	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>

Ver02/13

REGISTRATION No

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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PHC Ticket of Referral

## Receipt of Ticket of Referral

## For office Use Only

Details verified with PAS	<input type="checkbox"/>
TOR is legible and completely	<input type="checkbox"/>

Registration Number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	No.	No.	No.
Receiving officer signature	<input type="text"/>									

**Reasons for referral:** *History of presenting complaint*

**Past History**

**Current Treatment and any Allergies**

**Clinical Examination Findings**

**Investigations by referring doctor prior to referral**

	Urine
	Blood
	E.C.G.
	Chest X-ray
	Others

**Is the patient presently attending MOP/SOP/Other Relevant Clinic?**

Name:	
Registration	
Signature & Rubber Stamp	

<b>URGENT CASES ONLY</b>	
Discussed with MDH Consultant	
Name of Consultant:	
Date: _____	Time: _____

Doctors are to state clearly their medical council registration number, name, contact details (email and mobile no. optional)

**Notice:** Improperly or incomplete filled ticket of referrals, will be returned to the referring doctor.  
Referrals to Health Centres will not be accepted at MDH.

Dear Patient, you will receive your appointment details within the next 20 working days. Please keep this receipt as a reference. Should you fail to receive the appointment within the stipulated period, you are kindly requested to call this number: 2545 4213 (08:00 - 15:00)

Għażiż Pazjent, għandek tirċievi l-appuntament tiegħek fi żmien 20 jum (eskluz Sibtijiet, Fudud u Festi Pubbliċi). Int mitlub iżżomm din l-irċevuta bħala referenza. Jekk ma tirċivix l-appuntament tiegħek fiż-żmien indikat, nitolbuk iċċempel fuq dan in-numru: 2545 4213 (08:00 - 15:00)