MINISTERU GĦAS-SAĦĦA,
L-ANZJANI U KURA FIL-KOMUNITÀ

MALTA

MINISTRY FOR HEALTH,
THE ELDERLY AND COMMUNITY CARE

TICKET OF REFERRAL TO THE A&E DEPARTMENT (DH22B)

Date :_____

PATIENT DETAILS

Time :_____

I.D. / Passport Number :_____ **Age :**_____

Name & Surname :_____ **Gender M/F**

Address :_____

_____

Telephone Number :_____

CONTACT DETAILS OF NEXT OF KIN / GUARDIAN

Name & Surname :_____

Address :_____

_____

Telephone Number :_____

Reason for Referral (Including History of Presenting Complaint):

Medical History Y☐ N☐

If Yes

Diabetes Mellitus	Y☐ N☐	TIA/Stroke	Y☐ N☐
Hypertension	Y☐ N☐	Anxiety	Y☐ N☐
IHD/CHF	Y☐ N☐	Depression	Y☐ N☐
Asthma/COPD	Y☐ N☐	Epilepsy	Y☐ N☐

Others _____

_____

_____

Surgical History Y☐ N☐

If Yes _____

_____

_____

_____

Social History

Smoking Y☐ N☐ No.of cigs.__

Recent Travel Y☐ N☐ Alcohol Y☐ N☐

Destination (When relevant)_____

Drug History Y☐ N☐

If Yes_____

Allergies Y☐ N☐

If Yes

Parameters (If Applicable)

Pulse ____ Pallor Y☐ N☐
BP ____ Dehydration Y☐ N☐
Resp. ____ Dyspnoea Y☐ N☐
Temp. ____ Oedema Y☐ N☐

Blood Glucose _____
Urinalysis _____
Pregnancy Test _____

Relevant Examination :

Treatment Given By Referring Doctor For This Condition.

Drug	Dose & Route	Time of administration

Further Notes (e.g. Receiving Consultant/Delegate Contacted When Relevant)

For more information, contact A&E Dept., Mater Dei Hospital on 25454078, 25454068 & 25453944.

Name & Surname of Referring Doctor (or stamp) :_____

Medical Council Registration Number. (or stamp) :_____

Contact Number (or stamp) :_____

Signature of Referring Doctor: :_____

E-mail of Referring Doctor (optional) :_____