www.umvuzohealth.co.za

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SPECIALIST REFERRAL FORM

Kindly ensure that the form is signed and contains all the required information and forward it together with the results of relevant special investigations to auth@rxhealth.co.za

PATIENT DETAILS (ALL FIELDS ARE MANDATORY)

Patient name and surname	

If the patient is not the main member, please list the name and surname of the main member

Name and surname	

Membership number		Membership number verified		Y		N	

Gender		Male		Female		Date of birth	Y	Y	Y	Y	M	M	D	D

ID number														

Cellphone number where member can be contacted	
E-mail address if available	

REFERRING PRACTITIONER DETAILS

Full name and surname	
Contact number (for professional interaction)	
E-mail address (for professional interaction)	
PR number	

SPECIALIST REFERRED TO

Specialist name and surname	
Discipline	
PR number	

Date of appointment	Y	Y	Y	Y	M	M	D	D

CLINICAL DETAILS

ICD 10 codes						

Date this condition was first treated	
Date of last consultation for this condition	

Reason for referral, please include relevant history, symptoms, and clinical findings

CLINICAL DETAILS CONTINUED

Treatment given thus far (please include details e.g., medication, dosage, frequency, duration etc.)

Height		Weight		BP		/	

SPECIAL INVESTIGATIONS

Investigation	Pertinent result	Copy included			
			Y		N
			Y		N
			Y		N

CO-MORBIDITIES / CHRONIC CONDITIONS

Date	Y	Y	Y	Y	M	M	D	D

Signature confirming that the above information is complete and accurate	