患者氏名　：
患者 ID　：

Patient Referral Document

Hospital name ______________________________

To Dr. ______________________________

Date (YYYY/MM/DD): ______/______/______

Patient name		**Sex**	☐Male ☐Female
Date of birth (YYYY/MM/DD)		**Age**	years old
Address			
Phone No. (Home)		**Phone No. (Mobile)**	
Occupation			
Diagnosis			
Purpose of referral			
Past medical history and family history			
Clinical course, test results, and treatment			
Medication			
Materials attached	☐No ☐Yes → ☐X-ray ☐CT ☐MRI ☐Endoscopy ☐Ultrasound ☐ECG ☐Blood test ☐Discharge summary		