TIONG BAHRU
Community Health Centre

Tick if referring from PCN Clinic ☐ _____ (Name of PCN)

Referral Form

PATIENT'S PARTICULARS

Name : _____

NRIC : _____ Date of Birth : _____ Gender : ☐ F / ☐ M

Address: _____

Contact No: _____ Date and Time of Appointment : _____

SERVICES REQUESTED (by appointment only)

☐ Digital Diabetic Retinal Photography (DDRP)

☐ Diabetic Foot Screening (DFS)

☐ Podiatry

- ☐ Corns ☐ Calluses ☐ Thickened Nails
- ☐ Trimming of Ingrown Toenails (nail avulsion procedure is not available)

PATIENT'S MEDICAL BACKGROUND

Height : _____ m Weight : _____ kg

Drug allergy: ☐ Yes ☐ No Specify : _____

Existing Medical Conditions		Date of diagnosis
☐ Diabetes / Type of insulin (if applicable)	: _____	_____
☐ Hyperlipidaemia		_____
☐ Hypertension		_____
☐ Others : _____		_____

	Date of last test
HbA1c : _____	_____
Fasting Blood Sugar : _____	_____
LDL: _____	_____
TG: _____	_____

Current Medication: _____

Referral Clinic (Clinic Stamp with tel and fax):

Name of Doctor : _____

MCR No : _____

Signature : _____

Date : _____

Blk 19 Jalan Membina
#01-24, Singapore 163019
Tel: 6376 0158 | Fax: 6271 7239
tiongbahruchc@singhealth.com.sg

Operating Hours
Monday to Friday : 8:30am to 12:00pm
1:00pm to 5:00pm
Closed on Saturdays, Sundays & Public Holidays

Singapore General Hospital
SingHealth