



Premiermedicaid

NIGERIA LIMITED

(HEALTH MAINTENANCE ORGANISATION- HMO)
NATIONAL HEALTH INSURANCE SCHEME

REFERRAL FORM

Date: _____

FROM (HEALTH FACILITY) _____

REG. NO: _____

REFERRED TO: _____

PATIENT'S NAME: _____

PIN: _____

CLINICAL FINDINGS: _____

INVESTIGATION _____

PROVISIONAL DIAGNOSIS _____

REASON FOR REFERRAL _____

NAME OF REFERRING PERSONNEL _____

SIGNATURE & STAMP _____

DATE _____

ACKNOWLEDGEMENT SLIP

RECIPIENT'S FACILITY: _____

PATIENT'S NAME _____

PIN: _____

ACTION TAKEN: _____

_____ DOCTOR'S SIGNATURE

DATE _____