ALL INDIA INSTITUTE OF MEDICAL SCIENCES
Mangalagiri, Andhra Pradesh

Annexure-F

Referral Form for Non-availability of Investigations/ Treatment

Name of the Patient: Age/Gender:

EHS Employee ID: UHID:

Department: Date of Request:

Diagnosis:

Reason for Referral:

Further Guidance on Referral:

Signature & Stamp
Treating Faculty

Signature & Stamp
HOD

Signature & Stamp
Medical Superintendent