MDH
Tel: 2545 0000
2545 4213
bookingoffice.mdh@gov.mt

SPTAR MATER DEI

TICKET OF REFERRAL

TO BE FILLED BY THE REFERRING DOCTOR

Primary HealthCare

PHC
Tel: 21 231 231

Notice: Routine appointments will be given, unless the referring doctor calls the intended specialist, who can be contacted on the dedicated line at MDH as instructed.

PATIENT DETAILS

ID Card No. | Date D D M M Y Y

Name

Address

Telephone | Mobile

Age yrs | DOB D D M M Y Y | Gender M F

NEXT OF KIN

Name

Telephone | Mobile

REFERRED TO:

Medicine:	Surgery:	Other Specialities:	Primary HealthCare
Asthma Clinic	Audiology	Chinese	A.C.C
Cardiology	Bariatric (weight loss)	Dental	M.C.C
Chest Clinic	Breast Clinic	Dermatology	Cardiology
Diabetes	Dizziness Clinic	Dietitian/ Nutrition	Physiotherapy
Endocrine	E.N.T	Genetics	Podiatry
Gastroenterology	Endocrine (surgery)	Geriatrics	Nutritionist
General	General Surgery	GU Clinic	Dietician
Haematology	Hepatobiliary	Gynae	Primary Eye Screening
Infectious diseases	Lower GI	Obstetrics	Speech and Language
Lipid Clinic	Neurosurgery	Oncology	Diabetes
Nephrology	Ophthalmology	Paediatrics (0-16yrs)	ECG
Neurology	Orthopaedics	Paediatrics Speciality	Orthopaedic
Rapid Access	Paediatric Surgery	Pain Clinic	Immunisation
Respiratory	Plastic Surgery	Psychiatric	Gynae
Rheumatology	Upper GI	Thalassaemia	GP appointment clinic
	Urology	Tissue Viability	Scoliosis
	Vascular Surgery		ADSC
			Endocrine

REGISTRATION No

Ver02/13

Receipt of Ticket of Referral | For office Use Only

Details verified with PAS		Registration Number	D D M M Y Y No. No. No.
TOR is legible and completely		Receiving officer signature	

Reasons for referral: *History of presenting complaint*

Past History

Current Treatment and any Allergies

Clinical Examination Findings

Investigations by referring doctor prior to referral

	Urine
	Blood
	E.C.G.
	Chest X-ray
	Others

Is the patient presently attending MOP/SOP/Other Relevant Clinic?

Name:	
Registration	
Signature & Rubber Stamp	

URGENT CASES ONLY
Discussed with MDH Consultant
Name of Consultant:

Date: ______________ Time: ______________

Doctors are to state clearly their medical council registration number, name, contact details (email and mobile no. optional)

Notice: Improperly or incomplete filled ticket of referrals, will be returned to the referring doctor.
Referrals to Health Centres will not be accepted at MDH.

Dear Patient, you will receive your appointment details within the next 20 working days. Please keep this receipt as a reference. Should you fail to receive the appointment within the stipulated period, you are kindly requested to call this number: 2545 4213 (08:00 - 15:00)

Għażiż Pazjent, għandek tirċievi l-appuntament tiegħek fi żmien 20 jum (eskluż Sibtijiet, Ħdud u Festi Pubbliċi). Int mitlub iżżomm din l-irċevuta bħala referenza. Jekk ma tirċivix l-appuntament tiegħek fiż-żmien indikat, nitolbuk iċċempel fuq dan in-numru: 2545 4213 (08:00 - 15:00)