General Referral Form

Thank you for your referral. A referral coordinator will handle your referral and ensure your patient is seen in a timely manner. For questions, please call **345-325-9000, ext. 1** **OR** **345-949-6066, ext. 1,** M-F 9am-5pm.

Please complete referral and send corresponding records to **DH.referrals@doctorshospitalcayman.com**.

Referred to

Dr. Name/Department

Date (DD-MM-YYYY)

Patient details

MRN no.

Title ☐ Miss ☐ Mrs. ☐ Ms. ☐ Mr.

First Name

Last Name

Sex ☐ Male ☐ Female ☐ Other

Date of Birth (DD-MM-YYYY)

Mobile Phone Number

Home Phone Number

Address

Work Phone Number

Legal Guardian Name

Relationship

Guardian Phone Number

Referral details

Referring Doctor (please print name)

Signature

Date of Referral (DD-MM-YYYY)

Phone Number

Fax Number

Patient Type

☐ Outpatient

☐ Inpatient

Referring Doctor's Address

Reason for referral

Urgency

☐ Non-urgent ☐ Urgent

☐ Semi-urgent ☐ Stat

Insurance Provider

Policy #

* Incomplete forms will be returned

Clinical information

Length of time since symptoms began

Description of symptoms

Medication/treatment received

Active medications

Findings and/or investigations

Current and past management

Relevant PMH

Surgical history

Family history

Special instructions to patient

- [ ] Bring diagnostic reports/results
- [ ] Bring medications

Other

*Incomplete forms will be returned

DH Doctors Hospital

16 Middle Road, George Town | Direct Line: (345) 949-6066 | Care Centre: (345) 325-9000 | doctorshospitalcayman.com