SRI KOTA SPECIALIST MEDICAL CENTRE

Referral Form

Date: ________________

To,
Dr ________________________

☐ The Consultant Paediatrician
☐ The Consultant O & G
☐ The Consultant Physician
☐ The Consultant ENT
☐ The Consultant Ophthalmologist
☐ The Consultant Pathologist
☐ The Consultant Radiologist
☐ The Consultant Radiotherapist & Oncologist
☐ The Consultant Urologist
☐ The Consultant Nephrologist
☐ The Consultant Neurologist
☐ The Physiotherapist
☐ The Consultant Surgeon
☐ The Consultant Orthopaedics Surgeon
☐ The Consultant Oral & Maxillofacial Surgeon
☐ The Consultant Cardiologist
☐ The Consultant Cardio Thoracic Surgeon

Imaging Service Require:

☐ X'ray
☐ Ultra-sound
☐ CT Scan
☐ Mammogram
☐ Angiogram / PTCA
☐ MRI

Examination Require : ____

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(Fold here)

Dear Doctor,

Patient's name : ________________________

I. C. No. : ________________________

Thank you.

(Fold here)

Referring Doctor / Clinic / Tel.
Chop & Signature

Referral Letter

SRI KOTA SPECIALIST MEDICAL CENTRE

Jalan Mohet, 41000 Klang, Selangor D. E.
Tel: 03-33733636 Fax: 03-33736888

Consultation Hours:

Monday - Friday : 9.00am - 1.00pm
2.00pm - 5.00pm
Saturday : 9.00am - 1.00pm
Emergency Dept. : 24 hours

Location Map

SRI KOTA SPECIALIST MEDICAL CENTRE
The Heart of Healthcare