PATIENT REFERRAL SLIP

National Programme for Prevention and Control of Cancer, Diabetes, CVD and Stroke (NPCDCS)

S. No:
Date:

STATE	DISTRICT	BLOCK/PHC	SUB CENTRE

A. NAME/ AGE / SEX:	b. ADDRESS :
C. PH. / MOBILE / NEIGHBORHOOD MOBILE	

Brief History of illness (if any):

Suspected for:

1. **Diabetes** (Random Blood Sugar above 140 mg/dl) ☐
2. **Hypertension** (Blood pressure above 140/90 mmHg) ☐
3. **Common Cancer:** Specify_____________________
4. **Positive TB Symptoms:**
   - Cough of any duration ☐
   - Fever ☐
   - Weight loss ☐
   - Night sweat ☐

Referred to: ……………………………………………………….

Referred by: ……………………………………………

Mobile No: …………………………….

Signature:
Name:

**To be issued by Medical Officer at Health Facility.*

(One copy to be retained at Health Facility and the other copy to be carried by the patient for referral and follow up)