

Referral Form

Diabetes Support Services

EASTERN
COMMUNITY
HEALTH CENTRE



Changi
General Hospital
SingHealth

For Appointment,
Eastern CHC (Tampines)
Tel: 6782 6885 Fax: 6782 9591

PATIENT'S PARTICULARS (or affix patient's label)

Name: _____
NRIC: _____
Date of Birth: _____ Gender: F / M
Address: _____
_____ Contact No.: _____
Date of Appointment: _____
Time of Appointment: _____

SERVICES REQUESTED (by appointment only)

☐ Digital Diabetic Retinal Photography (DDRP) ☐ Diabetic Foot Screening (DFS)

☐ Dietetic Service (DS)

PATIENT'S MEDICAL BACKGROUND

Drug allergy: ☐ Yes ☐ No Specify: _____

HbA1c Results: _____ Date of last HbA1c test: _____

Fasting Blood Sugar: _____ Date of last Fasting Blood Sugar test: _____

Existing Medical Conditions

	Year of Diagnosis		Year of Diagnosis
☐ Diabetes	()	☐ Hyperlipidaemia	()
☐ Hypertension	()	☐ Others: _____	()

Current Medications: _____

Referral Clinic (Clinic Stamp with tel and fax):

Name of Doctor: _____

MCR No.: _____

Signature: _____

Date: _____

Referrals for these services are valid for 6 months from date of referral

Operating Hours (By appointment only)

Monday to Friday
8.30 am to 12.00 pm
1.00 pm to 5.00 pm

Eastern Community Health Centre (Tampines)

Our Tampines Hub 1 Tampines Walk,
#03-33, Singapore 528523
Tel: 6782 6885 Fax: 6782 9591

(Updated July 2022)