



BT HEALTH & DIAGNOSTICS CENTRE

REFERRAL FORM

PATIENT DETAILS

LAGOS STATE UNIVERSITY
TEL: 08181283222, 08142933905, 08146129000
Email: info@bthdc.com.ng
Website: www.bthdc.com.ng

Date: 20/25

☒ Urgent ☐ Routine

Patient's Name: A. J. O. O. O.

Date of Birth: / /

LMP: / /

Age: /

Gender: M ☒ F ☐

Phone No/Email: /

Clinical Details & Diagnosis: /

REFERRING DOCTOR'S DETAILS

Referral Doctor: Dr. A. J. O. O.

Phone Number: 08181283222

Consultant in Charge: Dr. O. O. O.

Hospital/Clinic/Dept/Ward: /

Bill to ☐ Patient ☐ Hospital ☐ Company/HMO

Company/HMO

Company/Hospital name: /

Enrollee No: /

Preliminary Report Request: ☐ Yes ☐ No

Final report sent to ☐ Doctor ☐ Patient

BIOCHEMISTRY

HAEMATOLOGY

ENDOCRINOLOGY

SEROLOGY

MICROBIOLOGY

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