SPECIALIST REFERRAL

Authorisation number: ___________________

Important Information

1. You must be referred by your Network GP to a Specialist.
2. The completed form must be faxed to 086 762 4050 or email referrals@topmedms.co.za for an authorisation before referral to a Specialist. Please ensure this is done in advance of making the appointment to see the Specialist – preferably 3 days prior.
3. The patient must take this Specialist Referral form with the authorisation number quoted on the form with him/her to the Specialist.

PATIENT INFORMATION

Member Number:___________________________________ Patient Date of Birth:__________________ Dependant Code: _______________

Patient Name:____ Surname: ____

Patient Tel No: (W)_____________________________ (H)_____________________________Cell No:__________________________________

Email ____

REFERRING GENERAL PRACTITIONER'S DETAILS

GP's Name and Surname:____ Practice No:__________________________

GP's Tel No: (W)______________________________ (H)______________________________ Cell No:__________________________________

Email ____

SPECIALIST PRACTITIONER'S DETAILS

Specialist's Name and Surname:____ Practice No:__________________________

Specialist's Tel No: (W)_________________________ (H)__________________________ Cell No:____________________________________

Email ____

DIAGNOSIS & TARIFFS

ICD10 code/s	
Tariff/Procedure	

REASON FOR REFERRAL

Reason for referral	Yes / No		Please specify
Presenting symptoms for Specialist to address (please provide ICD10 codes above)	Yes	No	
High burden of disease requiring more complex care	Yes	No	

Second opinion	Yes	No							
To exclude pathology (e.g. Request for scope) Please specify presenting symptoms, ICD10 and treatment if any	Yes	No							
Abnormal results/clinical findings requiring specialist review (e.g. ECG abnormal, Evidence of target organ damage, raised cardiac enzymes, severe anaemia, etc)	Yes	No							
Poor disease control despite maximum medical management Please provide the relevant medical information	Yes	No	BP	HbA1c	eGFR	CRP	PSA	Hb	Other
How long has the patient had symptoms?									
Are there additional risk factors that require specialist management?	Yes	No							

Please specify investigations if any (Please attach copies of lab reports/x-rays if available): ____

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Please specify treatment provided and the length of time (e.g. Medication, Dose, date started, date completed and response to treatment):

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General Practitioner's Signature: ___________________________________ Date: _____________________________________