Referral Slip

(For referral of beneficiary of AB-SSBY from Govt. Hospital to empanelled private Hospital)

AB-SSBY ID: _____ Referral Slip No:_____ Date:_____

If AB-SSBY e-card is not generated, Ration Card No./Construction ID/PAN Card No.:_____

Name of Patient:_____

Age of Patient: _____Gender:_____Mobile No. of the Patient:_____

Address of Patient:_____

Details of illness/Present Condition of the patient : _____

_____

_____

Reason of referral (Check the box or write if any other reason)

   (i)   Treating Doctor not available: ☐

   (ii)   Required Infrastructure/equipment/medicine not available: ☐

   (iii)   Beds not available :   ☐

   (iv)   Procedure/ treatment not done/available in the hospital: ☐

   (v)   Any other reason:_____

             _____

             _____

Name of Hospital where referral is made:

   (i)   Government Hospital; If yes, name of the hospital:_____

   (ii)   Empaneled Private Hospital; If yes, name of the hospital:_____

Name and Signature	**Signature of Arogya Mitra**	**Signature of Beneficiary/**
of Duty Medical Officer/SMO *(mandatory)*	*(optional in case of emergency)*	**Attendant***(mandatory)*