TEL: (234-1) 4701813, 7747150, 8045263, 8980368 FAX: (234-1) 5550508
E-mail: info@totalhealthtrust.com

Name & Address of Secondary Care Provider (SCP)

____

____

____

Name & Address of Referring Care Provider

____

____

____

Date ____________________

Dear Doctor,

REFERRAL LETTER

Enrolee Identification No

Re: ____

Name of Enrollee

Medical History:

The above named enrollee is therefore being referred to you for CONSULTATION/TREATMENT/PROCEDURE.
(Delete as applicable)

Kindly furnish referring PCP and THT with your findings for appropriate action.
NB: Specialist Care Providers are to act on specific request.

____

Signature & Official Stamp of Referring (PCP)