CUBCHS Card No/ ID No...........................................................Mobile No..........................................................

Name of Employee .................................................................. Designation.......................................................

Name of Pateint.......................................................................... Relationship......................Age...........Sex............

Hospital suggested ....................................................................................................................................................

Short clinical notes and duration of illness ..............................................................................................................

....................................................................................................................................................................................

....................................................................................................................................................................................

....................................................................................................................................................................................

Signature of the Employee

Date Signature of the University Doctor/Authority

- ------------------------------------------------------------------------------------------------------------------------------------

OFFICE COPY

**** **nf{k.k fcgkj dsUnzh; fo'ofo|ky;**

Central University of South Bihar

**(A Central University Established by an Act of Parliament)**

**NAAC Accreditation: Grade “A**

 SH- 7, Gaya-Panchanpur Road, Village- Karhara, Post- Fatehpur

 P.S. –Tekari, District-Gaya (Bihar) Pin Coade- 824236

REFERRAL SLIP

CUBCHS Card No/ ID No............................................................ Mobile No.......................................................

Name of Employee ........................................................................Designation.........................................................

Name of Pateint..........................................................................Relationship.................Age...........Sex............

Hospital suggested ....................................................................................................................................................

Short clinical notes and duration of illness ..............................................................................................................

....................................................................................................................................................................................

....................................................................................................................................................................................

....................................................................................................................................................................................

Signature of the Employee

Date Signature of the University Doctor/Authority

CUBCHS Card No/ ID No...........................................................Mobile No..........................................................

Name of Employee .................................................................. Designation.......................................................

Name of Pateint.......................................................................... Relationship......................Age...........Sex............

Hospital suggested ....................................................................................................................................................

Short clinical notes and duration of illness ..............................................................................................................

....................................................................................................................................................................................

....................................................................................................................................................................................

....................................................................................................................................................................................

Signature of the Employee

Date Signature of the University Doctor/Authority

- ------------------------------------------------------------------------------------------------------------------------------------

OFFICE COPY

**** **nf{k.k fcgkj dsUnzh; fo'ofo|ky;**

Central University of South Bihar

**(A Central University Established by an Act of Parliament)**

**NAAC Accreditation: Grade “A**

 SH- 7, Gaya-Panchanpur Road, Village- Karhara, Post- Fatehpur

 P.S. –Tekari, District-Gaya (Bihar) Pin Coade- 824236

REFERRAL SLIP

CUBCHS Card No/ ID No..............................................................Mobile No.......................................................

Name of Employee ........................................................................Designation.........................................................

Name of Pateint..........................................................................Relationship.................Age...........Sex............

Hospital suggested ....................................................................................................................................................

Short clinical notes and duration of illness ..............................................................................................................

....................................................................................................................................................................................

....................................................................................................................................................................................

....................................................................................................................................................................................

Signature of the Employee

Date Signature of the University Doctor/Authority