Table 1

The National Health Insurance Hospital (Clinic) Examination Referral Form (Referred to Hospital (Clinic))

Basic information of beneficiary	Name		Date of birth	YY MM DD
			National identification card No.	
	Allergy			
	Preliminary diagnosis			
Referring hospital/clinic	Code		Address	
	Name			
	Name of physician		Signature/seal of physician	Contact phone No. / Fax No.
	Date of issuance	YY MM DD	Expiry date	YY MM DD
Code of examination item		Name of examination		

Name of the designated medical care institution where the beneficiary shall receive the examination service	Address	Contact person	Contact phone no.

Results of examination: (Below shall only be filled out by the contracted medical care institution which accepts the referral)

Signature/seal of medical personnel conducting the examination: _____

Date of examination (test): YY MM DD Date of report: YY MM DD

※ The examination of the item specified in this form is limited to one time only.

Part I: shall be kept by the contracted medical care institution which accepts the referral.
Part II: shall be replied to the referring hospital/clinic by the contracted medical care institution which accepts the referral.
Part III: shall be kept by the referring hospital/clinic.