Table 2

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

Code of the contracted medical care institution:

Part II: shall be replied to the referring hospital/clinic by the accepting hospital/clinic.
Part I: shall be kept by the accepting hospital/clinic for record purposes

Part III: shall be kept by the referring hospital/clinic.

Referring hospital/clinic

Basic information of the beneficiary	Name		Date of birth		National identification card No.
			YY MM DD		
	Contact person	Phone number	Contact address		
Abstract of medical records	**A.** Abstract of medical condition (Chief complaint and short history)		**D.** Allergy:		
	B. Diagnosis ICD-10-CM Name of illness: 1. (Primary diagnosis) 2. 3. **C.** Abstract of examination and treatment 1. Results of the latest examination 2. Name of the latest medication or operation Date: Date: Report:				
Purpose of referral	1. ☐ Emergency care 4. ☐ Further examination: examination items 2. ☐ Inpatient care 5.☐ Follow-up by referral-back, referral or suitable hospital/clinic 3. ☐ Outpatient care 6. ☐ Others				
Address				Fax No.: Email address:	
Physician	Name		Department	Contact phone No.	Signature/seal of physician
Date of issuance	YY MM DD		Scheduled date of visit:	YY MM DD Department Clinic No. No.	
Recommended hospital/ clinic	Hospital/clinic name: _____ (must be filled out) Department: _____ (must be filled out) Physician: _____ Address: _____ Phone No.: _____				
Valid period	YY MM DD				

<table>
<tr><td rowspan="5">Accepting hospital/clinic</td><td>Handling</td><td colspan="8">1. ☐ The patient received emergency care and was referred to Hospital
2. ☐ The patient received emergency care and was admitted to Ward of this hospital for treatment
3. ☐ The patient was admitted to Ward of this hospital for treatment
4. ☐ The patient received medical outpatient care from the Department of this hospital
5. ☐ The patient received adequate treatment and was referred back to the referring hospital/clinic with following recommendations:
6. ☐ Others</td></tr>
<tr><td>Abstract of treatment</td><td colspan="8">1. Primary diagnosis 2. Name of medication or operation 3. Results of examination by computer-aided diagnosis

ICD-10-CM/PCS:
Name of illness:</td></tr>
<tr><td>Name of hospital/ clinic</td><td colspan="4"></td><td colspan="2">Phone No. or Fax No.:
Email address:</td><td colspan="2"></td></tr>
<tr><td>Physician</td><td>Name</td><td></td><td>Department</td><td></td><td>Signature/seal of physician</td><td></td><td>Date of reply</td><td colspan="2">YY MM DD</td></tr>
</table>

※ **This form is intended to be used for one referral only.**

※ **All columns are required fields to be filled out. For items not required under Article 7 of the Regulations, please indicate "N/A" if not applicable.**

※ **A contracted hospital or clinic providing point of care or mobile medical services under an NHI plan or project does not need to fill in Part II of this Referral Form when referring its beneficiary to the same institution to continue receiving medical treatment.**