CHIEF MINISTER AROGYA ARUNACHAL YOJANA (CMAAY)

Referral Letter

Ref. no……

Part -I (To be filled & generated by Arogya-Mitra from the system)				
Sl. No.	**PARTICULARS**	**INFORMATION (All columns are mandatory)**		
1	Name of referring hospital:			
2	Name of the patient:			
3	Age:		Gender:	Male ☐ Female ☐ Others ☐
4	Mobile No.		Aadhar No.	
5	UR No.			
6	Relationship with HoF			
7	Address:			
8	Referred Speciality (with Code):			
Part – II (To be filled by referring doctor)				
9	Case History:			
10	Provisional Diagnosis:			
11	Treatment given:			
12	Treatment advised:			
13	Provisional Package selected:			
14	Name of the hospital recommended:			
15	Reason for referral (Please mark 'V' if available and 'X' if not available:			

(i) Doctor/Expertise: ☐ **(ii) Equipment/Other :** ☐

Please specify for 'X' marked above:

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I certify that the above-named patient, to the best of my medical judgment require referral to higher centre for the reason(s) mentioned above. I have informed my patient and/or family about the need for referral. I understand that MSP/PMU can contact me to review and verify my action. I further certify that I am member of Arunachal Pradesh Health Service (APHS) and responsible for the medical dereliction of my patient's care.

Name of the Doctor:		
Designation:		
Mobile Number:		
APMC Reg No.:		
Date of referral:		**Signature of the doctor with Seal**

Note:

1. If the patient goes directly to the hospital out of State without approval of the govt. Doctor, this will be repudiated / rejected.
2. This referral letter will be valid only when it is signed & stamped by a government hospital which could be a PHC, CHC or district hospital subject to approval from Program Management Unit (PMU)of CMAA Society.