# CENTRAL COALFIELDS LIMITED

(A Subsidiary of Coal India Ltd.)

Medical Department

## PROFORMA FOR OUTSIDE REFERRAL/REVISIT

**(To be submitted in duplicate)**

Patient's Name : ..... Age ..... Sex : M ☐ / F ☐

Employee's Name : ..... Date of Birth : ..... Age : .....

Designation : ..... Relationship : .....

Place of Posting : Unit : ..... Area : .....

Employee Code No. : ..... Photo Med. Id. Card No. .....

Signature/LTI of Employee

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B. **DECLARATION FOR DEPENDENT PARENTS AND CHILDREN**

a. **SPOUSE :**

Declared that Shri/Smt. ..... is my husband/wife, and is not working in any organization/doing any business. He/she is wholly dependent upon me.

b. **PARENTS :**

Declared that Shri/Smt. ..... is my father/mother, who is totally dependent on me and normally residing with me and his/her income is less than Rs. 1500/- (p.m.)

c. **SON :**

Declared that my son is up to 25 yrs. of age, unmarried, a student, not earning and totally dependent upon me (proof is enclosed).

d. **DAUGHTER :**

Declared that my daughter aged ....., is unmarried and unemployed.

Passport size Photograph of the patient

Attested by Controlling Officer/ Personnel Manager

Signature of Controlling Officer

Signature/LTI of Employee

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C. **To be filled up by specialist of GNH/CHN**

1. Complaints of the patient : .....
2. History of the patient : .....
3. General Examination : .....
4. Present cinical findings in briet (Systematic Exam. related to disease/injury/Investigation)

   .....

   .....
5. Recent investigation Reports : .....

   .....

DIAGNOSIS .....

6. Nature of referral : Routine ☐ / Emergency ☐ / Post facto ☐
7. Proposed referral Institute : .....

   State Govt. ☐ \ PSU ☐ \Pvt. Empanelled ☐ \ Pvt. Not-Empanelled ☐

   If specific for outside state & Pvt. Institute, Justification thereof : .....

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9. No. of visit : .....
10. Amount of Medical Advance proposed : .....
    (With breakup/Justification as per entitlment)
11. Non-Medical Attendant : Yes ☐ / No ☐ If Yes, then justification : .....

**HOD at Concerne Dept.**

**Testing Doctor**

## D. To be filled up at the Area level

1. *Provisional diagnosis* :.....

2. Name of treating Doctor/Specialist :.....

3. Brief investigation Report/Treatment received :.....

   .....

4. Proposed referral Institute : .....
   State Govt ☐ \ PSU ☐ \Pvt. Empanelled ☐ \ Pvt. Not-Empanelled ☐

5. No. of Check up.....Mode of check up.....

6. Amount of the Medical Advance proposed.....

7. Outstanding Advance, if any: .....

8. Enclosure : Attested photograph of 1st page of Photo Med. Card & recommendation of specialist in Photo Med. Card Recent treatment and invstigation report.
   For review visit Previous sanction letter should also be enclosed along with last visit treatmet papers.
   Note : Section No. A.B.D. to be filled up at area level.

**Area CGM/General Manager** **AMO (Seal)** **Referring Doctor (Seal)** **Area Finance Manager**

E **Recommendation of Board Members of GNH/CHN**

CMO GNH/CHN | HOD – Medicine | HOD – Surgery | HOD Eye

Approval of Competent Authority

MS (HQ), CCL

CMS, CCL

**Director (Personnel), CCL**

CCL Press 793/12-13—100 Pads of 100 Lvs.