Premiere
Surgical Centre

Tel: (246) 537-3200
Fax: (246) 537-7001
Email: admin@premierebarbados.com

REFERRAL FORM

DATE: _____

NAME OF SURGEON: _____

NAME OF PATIENT: _____

DIAGNOSIS: _____

TYPE OF SURGERY: _____

REQUESTED DATE OF SURGERY: _____

TYPE OF ANAESTHESIA:

☐ General ☐ Conscious Sedation

☐ Spinal ☐ Local

EXPECTED DURATION OF SURGERY:

☐ 30 minutes ☐ 1 hour Other _____

☐ 2 hours ☐ 3 hours

C-ARM: ☐ Yes ☐ No

HISTOLOGY: ☐ Yes ☐ No

EXPECTED LENGTH OF STAY: _____

PRIVATE ROOM: ☐ SEMI-PRIVATE ROOM: ☐

_____
Signature of Doctor