Osaka University Hospital **Referral/Reservation Application Form (Clinical Section only)**

Social Service Department **FAX 06-6879-5081** Date of application:

Details of Applying Practitioner			
Clinical Section name		Dept.	
Address	〒		
Doctor			
TEL	Person in charge		FAX

[Patient's data]

Family Name First Name Middle Name		Date of birth		Age	
		TEL		Gender	Male Female
Purpose of referral	☐Advanced examination ☐Treatment ☐Others	☐In-hospital consultation Clinical section contact person about the expense( )			
Diagnosis (Subject or Diagnosis)	※Please fill in here or attach the referral letter (Please bring the referral letter on the day.)				
Desired Dept.	Specialized area ( )	Desired Doctor			
Consultation history of Osaka University Hospital		☐ YES Patient ID number - - ☐ NO			
Mark ○ at materials which you have ・No materials （X-ray・CT・MR・Endoscope・Ultrasonic waves・ECG・Inspection records・Others） ※The materials are necessary if you want to consult in Orthopaedic Surgery, so please mark the meterials.					
Others	Desired date ①MM/DD ②MM/DD ③MM/DD ④Not in particular（over 2weeks ・3weeks ・1month from applicated date） Inconvenient date(MM/DD) /				

Please fax this document to us. After reservation reception is completed, 'Reservation Form/ Registration Form' will be sent to you by fax. Please give it to the patient.
The reply will be given after the next day.

Departments			
Gastroenterology and Hepatology	Hematology and Oncology	Pediatric Surgery	Anesthesiology
Metabolic Medicine	Geriatrics and Hypertension	Ophthalmology	Obstetrics/ Gynecology
Respiratory Medicine	General Medicine	Otorhinolaryngology-Head and Neck Surgery	Pediatrics
Clinical Immunology	Kampo Medicine	Orthopaedic Surgery	Urology
Cardiovascular Medicine	Gastroenterological Surgery	Dermatology	Diagnostic and Interventional Radiology
Nephrology	Cardiovascular Surgery	Plastic Surgery	Radiotherapy
Neurology and Cerebrovascular Diseases	Breast and Endocrine Surgery	Neuropsychiatry	
	General Thoracic Surgery	Neurosurgery	