|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Referral form About this form: To gather basic information about the patient upon arrival at the referral level health  facility including their health condition. Can be used to compare health conditions of patients arriving  at a health facility via different modes of transport. Can also be used in conjunction with the Condition  Assessment form to track a patient and their health condition from a lower level health facility to the  referral facility. | | | | |
|  |  |  |  |  |  |
| **1** | Unique Identification Number: |  | | | |
| **2** | Date: |  | | | |
| **3** | Health Centre name:  *(If Self-Referral to Hospital answer SELF-REFERRAL)* |  | | | |
| **4** | Name and signature of Health Worker |  | | | |
| **5** | Patient’s name (sick person/child) |  | | | |
| **6** | Patient’s address |  | | | |
| **7** | **(Complete only in case of SELF-REFERRAL)**  Time of call made for emergency transport | **: AM/PM** | | | |
| **8** | **(Complete only in case of SELF-REFERRAL)**  Time of departure from start location/home | **: AM/PM** | | | |
| **9** | **(Complete only in case of SELF-REFERRAL)**  Time of arrival at health facility/hospital | **: AM/PM** | | | |
| **10** | Time of Referral requested | **: AM/PM** | | | |
| **11** | Time of Departure | **: AM/PM** | | | |
| **12** | Time of Arrival at Final Referral Hospital | **: AM/PM** | | | |
| **13** | Reason for referral |  | | | |
| **14** | Vital Signs Assessment | *Complete on table below* | | | |
|  |  |  |  |  |  |
|  | TEMP |  |  |  |  |
|  | PULSE |  |  |  |  |
|  | BP systolic (top) |  |  |  |  |
|  | BP diastolic (bottom) |  |  |  |  |
|  | RESPS |  |  |  |  |
|  | NEURO (Glasgow Coma Score) |  |  |  |  |
|  | URINE |  |  |  |  |
|  | **TOTAL** |  |  |  |  |

