9. REFERRAL FORM ☐ MOTHER ☐ NEWBORN

9.1. Clinic location : ☐ Korogwe Town Council hospital ☐ Other

9.1.1. If other, specify: _____

9.2. Form completed by : _____

9.3. Date of referral (dd/mm/yyyy): _ _ / _ _ / _ _ _ _

9.4. Referral clinic/hospital ☐ Korogwe District Hospital ☐ KCMC
☐ Bombo Regional Referral hospital ☐ Other

9.4.1. If other, give details : _____

9.5. Referral for:
☐ admission, medical treatment ☐ 2nd opinion
☐ admission, surgery ☐ other

9.6. Details : _____

9.7. Outcome of referral : _____

9.8. Results from additional tests : _____

9.9. Confirmed final diagnosis : _____

9.10. Treatment received at referral hospital should be documented: _____

9.11. CAMIPATA follow-up: ☐ Mother delivered ☐ continue ☐ excluded
Date of discharge (dd/mm/yyyy): _ _/_ _/_ _ _ _

DATA ENTRY:

1st entry done by: _____ Signature: _____ date: _ _/_ _/_ _ _ _

2nd entry done by: _____ Signature: _____ date: _ _/_ _/_ _ _ _