



# LIFEBRIDGE HOSPITAL

## COMPREHENSIVE MENTAL HEALTH / REHABILITATION

Northern Bypass Roysambu, Nairobi  
Behind Treat Hotel  
P.O. Box 1079-00600  
Nairobi  
.....0725133444  
lifebridgeke@gmail.com

### REFERRAL OUT FORM

DATE: .....

PATIENT NAME: .....

PHONE NUMBER: ..... AGE: ..... SEX: .....

Brief History:

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Investigations:

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Treatment:

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Diagnosis:

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Additional Comments:

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Referred to: .....

Reason for referral: .....

Referred by: .....

Signature: .....