ANNEX I.VI PATIENT REFERRAL FORM

For questions regarding referrals, please contact Insert Name at ##-###-####.

Country, Event, Year

Patient Referral Form

Date: 23/11/2025

Referral to: Maya Gupta Medical Center
Focal point: Priya Wilson Phone: +91-480-5187439
Location: District 5 Email: example@who.int

Referring from: Aarav Wilson Hospital
Focal point: Emma Patel Phone: +91-543-6581194
Location: Block 1 Email: example@hospital.org

Patient Information

Full Name: Priya Singh Phone: +91-981-7286413
Date of birth: 26/07/2001 Gender: Other
Address of discharge destination: Address #806, Street XYZ

Accompanied by care provider: Yes

Primary Diagnoses:
1. Cardiac issue
2. Cardiac issue
3. Burn injury

Other Diagnoses:
- Dehydration

Treatments initiated:
• Treatment A (Ongoing)
• Treatment B (Ongoing)
• Treatment C (Completed)
• Treatment D (Completed)
• Treatment E (Ongoing)
• Treatment F (Completed)

*Please attach medication chart at discharge

Reason for referral:
Inpatient

Transportation needs:
- Detail 1
- Detail 2

Follow-up requirements:
- Detail 1
- Detail 2

Functional Status:

Mobility: Crutches
Precautions: None

Self-care: Requires commode

Cognitive impairment: Yes

Assistive devices provided:
- Detail 1
- Detail 2

Assistive devices required:
- Detail 1
- Detail 2

Compiled by: Aarav Gupta
Signature: _____
Position: Medical Officer

NOTE: This form must accompany the patient’s file and a copy should be retained.

END OF REFERRAL FORM

FILE NUMBER: 003