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 Das Medical Center
Focal point: Lucas Nair Phone: +91-362-5994931
Location: District 9 Email: example@who.int

Referring from: Sophia Wilson Hospital
Focal point: Ishaan Kumar Phone: +91-302-4923316
Location: Block 8 Email: example@hospital.org

Patient Information

Full Name: Maya Wilson Phone: +91-491-5356885
Date of birth: 08/06/1951 Gender: Female
Address of discharge destination: Address #668, Street XYZ

Accompanied by care provider: No

Primary Diagnoses:
1. Fracture
2. Abdominal pain
3. Fracture

Other Diagnoses:
- Dehydration

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

*Please attach medication chart at discharge

Reason for referral:
Community

Transportation needs:
- Detail 1
- Detail 2

Follow-up requirements:
- Detail 1
- Detail 2

Functional Status:

Mobility: Bed bound
Precautions: Spinal precautions

Self-care: Requires commode

Cognitive impairment: Yes

Assistive devices provided:
- Detail 1
- Detail 2

Assistive devices required:
- Detail 1
- Detail 2

Compiled by: Olivia Martinez
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: 002