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: Rohan Brown Medical Center
Focal point: Emma Singh  Phone: +91-800-4369980
Location: District 8  Email: example@who.int

Referring from: Emma Brown Hospital
Focal point: Ishaan Wilson  Phone: +91-912-6705802
Location: Block 8  Email: example@hospital.org

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Patient Information
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Full Name: Sophia Reddy  Phone: +91-211-1675635
Date of birth: 23/03/2002  Gender: Male
Address of discharge destination: Address #830, Street XYZ

Accompanied by care provider: Yes

Primary Diagnoses:
1. Cardiac issue
2. Dehydration
3. Dehydration

Other Diagnoses:
- Cardiac issue

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

*Please attach medication chart at discharge

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Reason for referral:
Inpatient

Transportation needs:
- Detail 1
- Detail 2

Follow-up requirements:
- Detail 1
- Detail 2

Functional Status:

Mobility: Wheelchair
Precautions: Weight-bearing restricted

Self-care: Carer dependent

Cognitive impairment: Yes

Assistive devices provided:
- Detail 1
- Detail 2

Assistive devices required:
- Detail 1
- Detail 2

Compiled by: Priya Sharma
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: 004