

THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH, COMMUNITY
DEVELOPMENT, GENDER, ELDERLY AND CHILDREN



SEKOU - TOURE REGIONAL REFERRAL HOSPITAL
P.O. BOX 132 MWANZA, TEL: 028 40242 / 3

PATIENT REFERRAL FORM

Hospital Reg. Number..... 221597
Surname..... MNYAMGUSI
First name..... MURIA Middle name..... MATONYA
Age..... 67 Sex..... M
Religion..... M 4090 Ward/Unit..... RCH
Tribe.....
Next of Kin.....
Relationship.....
Phone Contact..... 0762648724
Physical Address..... Mwanza ICOMA - BUSUBWA

Date of Admission..... Referral Serial No. Medical Diagnosis..... ECZEMA

Referral to..... Dermatology Date of Referral..... 17/1/2022 Time..... PM

Present chief Complaints..... Skin disease

Patient's History..... Hx of severe itching all over body

Physical Examination.....

Provisional/Final Diagnosis..... Eczema

Investigations..... Not done

Treatment given prior referral.....

Reason (s) for referral..... For Dermatology to see.

Vital signs prior referral.....

BP	PR	RR	SPO ₂	TEMP	RBG	GCS/AVPU (Alert, Verbal response, Pain response, Unresponsive)	TIME

Referral Personnel..... Designation..... Signature..... Time.....

Escorting Personnel..... Designation..... Signature..... Time.....

Receiving Personnel..... Designation..... Signature..... Time.....

NOTE: One copy of referral form should be returned to the referring health facility

Feedback leaf let

Name of the Hospital..... Department.....

Patient Full Name..... Referral serial No.

Referral Diagnosis..... Confirmed Diagnosis.....

Comments.....

Name of the Dr./Staff..... Designation..... Signature/Stamp.....