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BMC/CHW/249696

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BARIADI TOWN COUNCIL



REFERRAL FORM

File No/Reg No: 00-20-80

Referral number:

Name of referring health facility: BARIADI TC HOSPITAL

Name of referral health facility: BMC

Name of the patient: WILLIAM KULWA age: 18YRS sex: M

Address: MWAMLAPA marital status: SINGLE

Date and time of admission: 5/2/2002

History: He was involved in a bicycle-motorcycle collision accident which occurred 3 days now, got injuries on scalp, on both lower limbs and 2 Bleed through both ears and nose. Now still

Physical: bleeding through right ear

Examination: Ill-looking, pale, confused, not oriented with place and time. BP 120/70 mmHg PR 88b/min PO 28%

Per vaginal examination:

Investigation done:

Provisional Diagnosis: Dx: HEAD INJURY/MULTIPLE LACERATED WOUNDS

Treatment given:

Reason for referral: For further invest & management

Name of escorting health provider:

Ambulance registration number:

Name of Doctor/Nurse: Dr. J. S. M. qualification: AMO

Signature & Stamp: [Signature] Date: 6/2/2002 Time: 11:57 AM

Feedback note:

Facility name:

Client name:

Problem identified:

Management given:

Prognosis:

Comments:

Name of doctor/Nurse:

signature:

title: