FORM NO. 12

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

GEITA REGIONAL REFERRAL HOSPITAL

P.O. BOX 40, GEITA.

PATIENT REFERRAL FORM

Hospital Reg. Number 00 - 21 - 88
Surname Lucia Samson
First Name ..... Middle Name .....
Age 17yrs Sex F M / (F)
Religion ..... Tribe ..... Ward/Unit 7
ADRESS ... Geita

Date of Admission 28/1/2026 Referral Serial No ..... Medical Diagnosis Open # of R/T Ankle + Dislocation

Referral to BMC Date of Referral ..... Time .....

Present chief Complaints Inability to use R/T lower limb

Patient's History Involved in MVA

Physical Examination Alert & stable vitals

Provisional/Final Diagnosis Ankle # R/T & Dislocation

Investigations X-Ray, # of Distal Tibia, Ankle dislocation

Treatment given prior referral

Reason(s) for referral ORIF, Expert orthopedic management

Vital signs prior referral

BP	PR	RR	SPO_2	TEMP	RBG	GCS / AVPU (Alert, Verbal response, Pain response, Unresponsive)
110/80	98	21	98	36.8	6.8	15/15

GEITA REGIONAL HOSPITAL
FOR MEDICAL OFFICER INCHARGE
P. O. BOX 40
GEITA

Referring Personnel Dr Wilfred Designation MD Signature/Stump [signature] Time 14:00pm

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 leaflet

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

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

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

Comments .....

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