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

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

PATIENT REFFERRAL FORM

Hospital Reg. Number 22266
Surname SALUM
First name AHMED Middle name ADAM
Age 09 YRS Sex MALE
Religion MUSLIM Ward/Unit ENT
Tribe RANCH
Next of Kin HAWA ADAM
Relationship BIOLOGICAL MOTHER
Phone Contact 0759 142952
Physical Address KIRUMBA

Date of Admission..... Referral Serial No. ..... Medical Diagnosis NASAL POLYPS

Referral to BMC ENT DEPT Date of Referral 20/01/2022 Time 12:03HRS

Present chief Complaints. Snoring -> 1yr

Patient's History -11-

Physical Examination GC Alert, afebrile, ⊖dyspnoic, ⊖pale

Provisional/Final Diagnosis NASAL POLYPS

Investigations —

Treatment given prior referral —

Reason (s) for referral Expert management

Vital signs prior referral

BP	PR	RR	SPO_2	TEMP	RBG	GCS/AVPU(Alert,Verbal response,Pain response,Unresponsive)	TIME
—	80	20	98	36.8	5.0mmol/L		12:03HRS

Referral Personnel VICTORIA SITTA Designation CO Signature Vm Time 12:03PM Stump.....

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

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

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

SEKOU TOURE REGIONAL HOSPITAL P.O. Box 132 MWANZA Referral Note SIGN Date

Feedback leaf let

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/Stamp.....

Nursing Service Form Vesion 1