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: 06-31-91/2022.
Surname: PATRICK
First Name: MELINA Middle Name: MISUNGWE.
Age: 27 Sex: F. M / F
Religion: CHRISTIAN Tribe: .... Ward/Unit: OBGY.
ADRESS: KATORO

Date of Admission: 06/02/2022. Referral Serial No: .... Medical Diagnosis: AKI / CKD.

Referral to: BMC.
Date of Referral: 07/01/2022. Time: 13:00HRS.

Present chief Complaints: Decreased Urine output for 4/7

Patient's History: 4days post laparotomy of ectopic pregnancy, c decreased urine output

Physical Examination: Stable, Slightly pallor, Edema

Provisional/Final Diagnosis: AKI R/O CKD

Investigations: Urea 24.6mg/dL, Creatinine 1.5mg/dL ↑, Hb 5.8g/dL.

Treatment given prior referral: BT PO, Iv ceftriaxone, Iv Metronidazole, Iv Frusemide 80mg.

Reason(s) for referral: for dialysis and other Management

Vital signs prior referral

BP	PR	RR	SPO₂	TEMP	RBG	GCS /AVPU(Alert, Verbal response, Pain response, Unresponsive)	TIME
128/67	122	20	98	37.1°C		15/15.	

Referring Personnel: David Malogo Designation: CO Signature/Stump: [signature] Time: 13:00HRS

Escorting personnel: .... Designation: ....

Receiving personnel: .... Designation: .... Signature: .... Time: ....

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

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/Stump: ....