Referral Form

Name of facility:	Referral Form		original /copy
Referred by:	Name: Dr EMMANUEL MARCO	Position: MO	
Initiating facility Name and address:	NGUDU HOSPITAL	Date of referral 20/1/2022	Time of referral 0500 Am
Telephone arrangements made	YES ✓ / NO	Facility tel No	Fax No
Referred to facility Name and address:	BMC		
Client Name	NEEMA ELIAS [illegible]		
Identity Number	00-76-37/2016	Age 20	Sex M / (F)
Client Address			
Clinical history	- H/O SVD @ GA 31/40 2hrs ago (currently P_{1+1} Lo) then developed DIB a/w chest tightness, Headache a/w Dizness - Had female MSB 3kg c̄ cord around the neck x1 - Prior SVD 3days ago she was not able to feel fetal mot. but had not pv-discharge/bleeding, no headache, no fever.		
Findings	O/E Afebrile pale +++, not dyspnoic, B/L pitting LL oedema ++, BP 126/68 mmHg PR-94 P/A uterus contracted, PVE normal lochia c̄ minor bleeding from lacerated fourc, vaginal wall, P/S normal Vesicular B/sound SPO_2 97% RA CVS Tachycardia		
Treatment given	Done FBP: Neutrophilia # 8.21, Hb 4.5g/dL, PLT 21, MRDT negative B/Group O Rh+		
Reason for referral	Given IV metronidazole 500mg stat, Inj x-PEN 5MU stat		
Documents accompanying referral	ⓒ Not given BT, because B/Group O Rh+ O/S		
Print name, sign &date	Name	Signature	Date
Escort nurse/doctor	Name	Signature	Date

Note to receiving facility: on completion of client management please fill in and detach the referral back slip below and send with patient or send by fax or mail

N.Y. MGANGA MKUU NA WILAYA KWIMBA

--------✂-------- Receiving facility – tear off when making back referral --------

Back referral form Facility name		Tel No.	Fax No.
Reply from (Person completing form)	Name:		
To initiating facility: *(enter name and address)*	Position:	Specialty:	
Client Name			
Identity Number		Age	Sex: M / F
Client Address			
This client was seen by: *(give name and speciality)*			On date:
Patient history			
Special investigation and findings			
Diagnosis			
Treatment /operation			
Medication prescribed			
Please continue with: *(meds,Rx, Follow –up, care)*			
Refer back to:			On date
Print name, sign &date	Name	Signature	Date

PDx: POST SVD, MSB WITH,
(i) SEVERE ANAEMIA NOT IN FAILURE
(ii) THROMBOCYTOPENIA – Severe

FOR - Coagulation Profile, possible platelet transfusion, Blood transfusion and further specialist review.