

FORM NO. 12

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



NAME OF HEALTH FACILITY

BUKOBA REGIONAL REFERRAL HOSPITAL

PATIENT REFERRAL FORM

Hospital Reg. Number..... 00-19-68
Surname..... DICKSON KARAGUKI
First Name..... VIVIAN Middle Name..... DICKSON
Age..... 4M Sex..... F M/F
Religion..... CHRISTIAN Tribe..... HAYA Ward/Unit.....

1) Presumptive PAIB & PCP
2) Severe B. pneumonia
3) Septicemia

Date of Admission..... 05/02/2021 Referral Serial No..... 441 Medical Diagnosis.....

Referral to..... BUGANDO MEDICAL CENTRE Date of Referral..... Time.....

Present chief Complaints..... Fever, convulsions and vomiting

Patient's History..... PTO

Physical Examination..... PTO

Provisional/Final Diagnosis..... PTO

Investigations..... FBP - Leukocytosis, BS for UPS (-ve)

Treatment given prior referral..... Ceftriaxone, Dexamethasone, paracetamol

Reason(s) for referral..... PTO

Vital signs prior referral

BP	PR	RR	SPO ₂	TEMP	RBG	GCS /AVPU (Alert, Verbal response, Pain response, Unresponsive)	TIME
213	72	82-98	38.7	3.8		Responds to pain	

Referring Personnel..... Bigenimana Malombe Designation..... M.O Signature/Stamp..... Time..... 9:30

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 leaf let

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

Referral serial No.....