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: 223225
Surname: SELEMAN
First name: FRANK Middle name:
Age: 37 Sex: M
Religion: Ward/Unit: EMD
Tribe:
Next of Kin:
Relationship:
Phone Contact:
Physical Address: BUSWELU

Date of Admission: 25/1/22 Referral Serial No. .... Medical Diagnosis: Open fracture of proximal left tibia

Referral to	BMC — Date of Referral: 26/1/2022 — Time:
Present chief Complaints.	Sustained injury of the left lower limb after was involved in a motor traffic accident
Patient's History	multiple injury after he was involved in a motor traffic accident
Physical Examination	Alert, not pale, not jaundiced, on LLE with cold extremities
Provisional/Final Diagnosis	Open fracture of the left proximal tibia
Investigations	X-ray of the left lower limb.
Treatment given prior referral	IM Ceftriaxone 1g, start IV fluid NS, RL
Reason (s) for referral	Open reduction and Internal fixation (Orthopedics review)

Vital signs prior referral

BP	PR	RR	SPO_2	TEMP	RBG	GCS/AVPU(Alert,Verbal response,Pain response,Unresponsive)	TIME
110/77	85	19	95	37	5.0	15/15	

Referral Personnel: Dr. SABRA Designation: MD Signature: J. Zakim Time: 9:02 Stump:
Escorting Personnel: Designation: RAD Signature: Time:
Receiving Personnel: Designation: Signature: Time:

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

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.................... Signatur

Nursing Service Form Vesion 1