BMC 248665

Referral Form

original /copy

Name of facility:				
Referred by:	Name: Dr Mchomba		Position: MO	
Initiating facility Name and address:	NGUDU DISTRICT HOSP		Date of referral 29.01.2022 Time of referral 10:27 HRS	
Telephone arrangements made	YES ✓	NO	Facility tel No	Fax No
Referred to facility Name and address:	BMC			
Client Name	THELEZA MADATA MAHALU			
Identity Number	00-01-38/2022		Age 19	Sex M (F)
Client Address	SHUSHI — KWIMBA			
Clinical history	H/o convulsion for ≈ 6hours See the attached sheet			
Findings	⇒ Refer to attached sheet			
Treatment given	⇒ Refer to attached sheet			
Reason for referral	For possible CTC scan of Brain tomography and further management			
Documents accompanying referral				
Print name, sign &date	Name Dr Mchomba	Signature		Date 29.01.2022
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.I. NGANGA MKUU WA WILAYA KWIMBA

Receiving facility – tear off when making 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			Sex: M F
Identity Number		Age	
Client Address			On date:
This client was seen by: *(give name and speciality)*			
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