BMC | returns # 248660

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

-KOU - TOURE REGIONAL REFERRAL HOSPITAL
P.O.BOX 132 MWANZA, TEL: 028 40242 / 3

PATIENT REFFERRAL FORM

Hospital Reg. Number 223768/2022
Surname Raza
First name Salma Middle name Mustapha
Age 7yrs old Sex
Religion Islam Ward/Unit EMD
Tribe Haya
Next of Kin ~~Aunt~~ Jenipher Revocatus
Relationship Aunt.
Phone Contact 0767175708.
Physical Address Kirumba.

e of Admission 28/01/2023 Referral Serial No. .... Medical Diagnosis ....

ferral to BMC. Date of Referral .... Time ....

esent chief Complaints. unable to use left upper 4hrs

atient's History S/He ~~stumbling~~ down from hammock

ysical Examination Alert, organised, apale, afebrile

visional/Final Diagnosis Distal fracture of humerus

estigations Elbow X-ray

eatment given prior referral im Diclofenac 20mg st

ason (s) for referral For orthopaedic team to review and manage.

/ital signs prior referral

BP	PR	RR	SPO_2	TEMP	RBG	GCS/AVPU(Alert,Verbal response,Pain response,Unresponsive)	TIME
			98	36		Alert.	

Referral Personnel F. Matan Designation MD Signature .... Time 10:37PM Stump ....

Escorting Personnel .... Designation .... Signature .... Time ....

Receiving Personnel .... Designation .... Signature .... Time ....

SEKOU TOURE REGIONAL HOSPITAL
P. O. BOX 132
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 .... Signature/Stamp ....

Nursing Service Form Vesion 1