File 249664

FORM NO. 12

NKWAKUZI

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: 00-19-35

Surname: Shilinzi

First Name: Mlsozi Middle Name: Bernard

Age: 34yrs Sex: (F) M / F

Religion: Christian Tribe: Sukuma Ward/Unit: ward 9 obs & Gyn. Postnatal

Date of Admission: 4/2/2022 Referral Serial No. 435 Medical Diagnosis: Severe Pre eclampsia ē Hepatorenal syndrome

Referral to: Bugando medical Centre Date of Referral: 5/2/2022 Time: 3:53 Pm

Present chief Complaints: epigastric pain 1 day, fast breathing

Patient's History: 34yrs (F) P3L3 Post SVD, Delivered Preterm neonate @ 36wks by Date 1.7kg scored 8/9 child kept on Antibiotics, mother refered as case of severe pre eclampsia. was induced and Delivered ē oxytocin 20 I.U in 1000mls RL, given nifedipine 20stat & methyldopa 500mg. After Delivered Pt still ē epigastric pain fast breathing;

Physical Examination: GCS 15/15 conscious, BP-138/94 PR-135 (full regular, tachycardic) RR-30 bpm typnic Pale ++ (dyspnetic) Afebrile 35.5°C, (L/E) pupils, no LL edema, catheter souls cocacola urine

Provisional/Final Diagnosis:

Investigations: FBP - neut 4.90%, Hb 11.4g/d, RFT - urea - 4.2 AST-913, ALT-674 elec K-4.13, Na 142 Cl-103, bedside Clotting factor 1hr not clotting 2CC

Treatment given prior referral: methyldopa 500mg tds 7/52, nifedipine 20mg OD 7/52, Vit K 10mg stat, FFP-30, Injection Heparine 5000 I.U, IV ceftriaxone 1gm BID, metro 500mg 8hrs x 5/7, IV fluid 2litre alternatively DNS / 1 2 ..

Reason(s) for referral: for Multidisplinary Care at BMC.

Vital signs prior referral

BP	PR	RR	SPO_2	TEMP	RBG	GCS /AVPU(Alert, Verbal response, Pain response, Unresponsive)	TIME
138/94	138	30-31	99% on Air	35.5°C	-	15/15 Conscious	

Referring Personnel: Fredick Anthony Baluhi Designation: GP Signature/Stump: [signature] [stamp: MEDICAL OFFICER IN CHARGE BUKOBA REGIONAL REFERRAL HOSPITAL] Time: 3:53 Pm

Escorting personnel: GETRUDE MWINEI Designation: EN Signature: [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 ....

Patient Full Name .... Referral serial No ....

Referral Diagnosis .... Confirmed Diagnosis ....

Comments ....

....

Name of the Dr./Staff .... Designation .... Signature/Stump ....