FORM NO. 12

UNITED REPUBLIC OF TANZANIA MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN GEITA REGIONAL REFERRAL HOSPITAL P.O. BOX 40, GEITA.	PATIENT REFERRAL FORM Hospital Reg. Number 00-33-76 Surname JUMA First Name MANYAMBULA Middle Name Age 29 Sex M M / F Religion SUKUMA Tribe Ward/Unit 8 ADRESS NGUNDA

Date of Admission 8/2/2022 Referral Serial No .... Medical Diagnosis Anterior mandibular # ē soft tissue injury

Referral to BMC Date of Referral 9/2/2022 Time 14:00hr

Present chief Complaints Inability to close jaw & difficult swallowing 1/7.

Patient's History Pt sustained injury after being involved in RTA ass ē bleeding inability to open jaw and swallowing

Physical Examination Alert, afebrile, ajaundiced G/E — # anterior mandible ē displacement, tooth extraction

Provisional/Final Diagnosis Anterior mandibular # ē soft tissue injury, traumatic tooth extraction

Investigations Skull Xray — Displaced anterior mandible #

Treatment given prior referral IV dexamethasone 8mg tds, IV ampiclox 500mg, IV metronidazole 500mg tds, IM tetanus toxoid stat

Reason(s) for referral for further management.

Vital signs prior referral

BP	PR	RR	SPO₂	TEMP	RBG	GCS /AVPU(Alert, Verbal response, Pain response, Unresponsive)	TIME
123/67	93b/m		97% RA		S. 8mmol	15/15	

Referring Personnel Ndongo Designation MD Signature/Stump [stamp: GEITA REGIONAL HOSPITAL FOR MEDICAL OFFICER INCHARGE P.O. Box 40 GEITA] Time 14:00hr

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 ....

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

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