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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: 025725/022. Surname: HAMISI First name: YUSRA Middle name: SHABAN Age: 12 Sex: M Religion: Muslim Ward/Unit: O.P.D Tribe: NYAMWEZI Next of Kin: Relationship: Phone Contact: Physical Address: NYAJOKA

Date of Admission........................ Referral Serial No. .... Medical Diagnosis..............................

Referral to: BMC - ENT surgeon	Date of Referral: 25/02/022 Time............
Present chief Complaints.	Mass protruding per auditory canal
Patient's History	for 5/12 no pain, she reported
Physical Examination	hx reduced Hearing for 5yrs now. Same clinically
Provisional/Final Diagnosis	?? Abscess of external Ear; ?neoma
Investigations	normal Hb
Treatment given prior referral	None.
Reason (s) for referral	ENT surgeon review & further mx.
Vital signs prior referral	

BP	PR	RR	SPO$_2$	TEMP	RBG	GCS/AVPU(Alert,Verbal response,Pain response,Unresponsive)	TIME
			95	37.2	4.8	15/15	

Referral Personnel: Dr Makame Designation: MD Signature: [signature] Time: 11:20 AM. Stump..........

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

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

SEKOU TOURE REGIONAL HOSPITAL P.O. Box 132 MWANZA Refferal ... 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..

....

.../Staff.............. Designation.............. Signature/Stamp..............