BMC 249273

THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH, 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 223877
Surname EMMANUEL
First name RAPHAEL Middle name MWANJOMBE
Age 26y Sex ME
Religion CHRISTIAN Ward/Unit MSW
Tribe MSUKUMA
Next of Kin /
Relationship SISTER
Phone Contact 0764 642986
Physical Address BUTONGWA

Date of Admission 30/1/22 Referral Serial No. ..... Medical Diagnosis Chronic Haematoma ? arterial Venous malformation

Referral to BMC Date of Referral 02/02/2022 Time 5:30 Pm

Present chief Complaints. Presents with a recurred Mutrom, & Lost of Consciousness

Patient's History Found in the bathroom, after he fell, lost of Consciousness, Mutrom.

Physical Examination Alert, GCS 15/15, moving Mutrom

Provisional/Final Diagnosis Ischaemic stroke, chronic haematoma, abnormal Venous fistula

investigations CT-Head, ABO, X-mel, Hb, G

Treatment given prior referral Mannitol, IV albumone, IV Ceftriaxone

Reason (s) for referral Neural Surgeon Review.

Vital signs prior referral

BP	PR	RR	SPO_2	TEMP	RBG	GCS/AVPU(Alert, Verbal response, Pain response, Unresponsive)	TIME
120/70	88	18	96%	36.4		GCS 15/15	

Referral Personnel Samson Designation MD Signature ..... Time 5:30 pm Stump .....

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

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

NOTE: One copy of referral form should be returned to the referring health facility

SEKOU-TOURE REGIONAL HOSPITAL P. O. Box 132 MWANZA Received SIGN Date

Feedback leaf let

Name of the Hospital ..... Department .....

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

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

Comments .....

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