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........223746
Surname........WEBIRO
First name........JULIUS........ **Middle name**........
Age........27yr........ **Sex**........MALE
Religion........ **Ward/Unit**........MOW
Tribe........
Next of Kin........
Relationship........
Phone Contact........
Physical Address........ONDOFFARU/SINAI

Date of Admission.....23/11/2022..... **Referral Serial No.** .... **Medical Diagnosis**.....Epidural Haemorrhage Temporal bone #

Time...16.50 hrs

Referral to........BMC........	**Date of Referral**........24/11/2022
Present chief Complaints.	Headache
Patient's History	Involved a MTA as a Cyclist
Physical Examination	Multiple Bruises, Sutured in occipital, convulsion
Provisional/Final Diagnosis	Mild TBI, Epidural Haemorrhage, # of Temporal Bone
Investigations	CT, XRAY, ABO, Hb 8 Exmda
Treatment given prior referral	Phenobarbitone, Manitol, IV ceftriaxone, Metro, Pcm
Reason (s) for referral	Epidural Hammorrhage, & Fracture of Temporal
Vital signs prior referral	

BP	PR	RR	SPO_2	TEMP	RBG	GCS/AVPU(Alert,Verbal response,Pain response,Unresponsive)	TIME
118/68	87	20	95%	36.4	6.	14/15 (M6, E4, V4	

Referral Personnel.....Samson/Smh.....**Designation**.....MD.....**Signature**.....Jo.....**Time**.........**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
Refferal Note
SIGN____
D te____

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/Stamp**................

Nursing Service Form Vesion 1