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: 22 64 46
Surname: MALOMO
First name: KASUMBA Middle name:
Age: 64 Sex: M
Religion: CHRISTIAN Ward/Unit: EMD
Tribe:
Next of Kin:
Relationship:
Phone Contact:
Physical Address: ILEMELA

Date of Admission: 12/2/22 Referral Serial No. ..... Medical Diagnosis: Fracture of femur.

Referral to: BMC Date of Referral: 12/2/22 Time:

Present chief Complaints. Inability to use the Rt limb.

Patient's History → Pt was involved in a RTA and sustained fracture of the Rt limb and was LOC after the incidence. with no bleeding per ear or nose.

Physical Examination - Alert not pale not jaundiced not cyanosed with no lower limb edema.

Provisional/Final Diagnosis Fracture of the Rt femur.

Investigations → X-Ray of the Rt femur.

Treatment given prior referral - Diclofenac IM (75mg)
- Back slab

Reason (s) for referral → Orthopaedic review.

Vital signs prior referral

BP	PR	RR	SPO_2	TEMP	RBG	GCS/AVPU(Alert,Verbal response,Pain response,Unresponsive)	TIME
135/70	110	75	98	-	-	Alert.	8:51 Pm.

Referral Personnel: Oliver M. Designation: MD Signature: O.M 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 Referral Note SIGN Dr.

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/Stamp:

Nursing Service Form Vesion 1