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..22645.....
Surname..Misomado.....
First name..Astenia..... Middle name..Kulwa.....
Age..78..... Sex..F.....
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..Schizophrenia.....

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

Present chief Complaints. - Talking inapropriate words

Patient's History - Known psychiatric pt on irregular unknown medication came with the complain of talking inapropriate words

Physical Examination - Alert but with GCS 14/15 not cyanosed not jaundiced with no lower limb edema.

Provisional/Final Diagnosis -Schizophrenia.

Investigations - MRDT -Ve

Treatment given prior referral -

Reason (s) for referral - Psychiatric team review

Vital signs prior referral

BP	PR	RR	SPO_2	TEMP	RBG	GCS/AVPU(Alert,Verbal response,Pain response,Unresponsive)	TIME
135/75	79	19	99	-	-	Alert	

Referral Personnel..Oliver M.....Designation..MD.....Signature..OM.....Time..9:06pm.....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 REFERRAL HOSPITAL
P.O. Box 132 MWANZA
Referral Note

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