FORM NO. 12

UNITED REPUBLIC OF TANZANIA MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN	PATIENT REFERRAL FORM
GEITA REGIONAL REFERRAL HOSPITAL	Hospital Reg. Number 00-22-7/2022
P.O. BOX 40, GEITA.	Surname
	First Name ZAWADI Middle Name MAKOYE
	Age 3/7 Sex f M / F
	Religion Tribe Ward/Unit NICU
	ADRESS RUNZEWE

Date of Admission 25/01/2022 Referral Serial No .... Medical Diagnosis (i) Spinal Bifida (ii) N. Jaundice

Date of Referral 26/01/2022 Time 11:00AM

Referral to	BMC
Present chief Complaints	Baby delivered by SVD bwt = 3kg, cried after delivery
Patient's History	c swelling/protrusion at the back, fever, yellowish coloration, able to suck
Physical Examination	Alert, afebrile, jaundice (+) P/A: NAD, LE: Dressed at the back
Provisional/Final Diagnosis	(i) Spinal Bifida (ii) CON. N. Jaundice
Investigations	
Treatment given prior referral	Iv gentam, iv ampiclox, for BF, Dressed done.
Reason(s) for referral	For pediatric surge- team.

Vital signs prior referral

BP	PR	RR	SPO$_2$	TEMP	RBG	GCS /AVPU(Alert, Verbal response, Pain response, Unresponsive)
	140bpm		93%RA	36.4°c		Alert

GEITA REGIONAL HOSPITAL FOR MEDICAL OFFICER INCHARGE P. O. BOX 40 GEITA

Referring Personnel Dr Festus James Designation MO Signature/Stump [signature] Time 11:00AM.

Escorting personnel .... Designation .... Signature .... Time ....

Receiving personnel .... Designation .... Signature .... Time ....

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 ....

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