


BMC 247926

<p style="text-align: center;">THE UNITED REPUBLIC OF TANZANIA MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN</p> <div style="text-align: center;">  </div> <p style="text-align: center;">SEKOU - TOURE REGIONAL REFERRAL HOSPITAL P.O. BOX 132 MWANZA, TEL: 028 40242 / 3</p>	<p style="text-align: center;">PATIENT REFERRAL FORM</p> <p>Hospital Reg. Number..... <u>222147/2022</u></p> <p>Surname..... <u>MUCH</u></p> <p>First name..... <u>VERONICA</u> Middle name..... <u>Jeremia</u></p> <p>Age..... <u>24yrs</u> Sex..... <u>FEMALE</u></p> <p>Religion..... <u>CHRISTIAN</u> Ward/Unit..... <u>GYNAS</u></p> <p>Tribe..... <u>SUKUMA</u></p> <p>Next of Kin..... <u>GEREMIA GERVAS</u></p> <p>Relationship..... <u>HUSBAND</u></p> <p>Phone Contact..... <u>078941 0789641800</u></p> <p>Physical Address..... <u>BUTIMBA</u></p>
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Date of Admission..... 19/01/2022 Referral Serial No. Medical Diagnosis.....

Referral to..... <u>Bmc</u>	Date of Referral..... <u>25/01/2022</u>	Time..... <u>12:24AM</u>
Present chief Complaints..... <u>General body weakness, failure to pass urine over the 24hrs</u>		
Patient's History..... <u>A PGL who presented w/ abd pain, had a wds of missed abortion she delivered a macerated baby but had retained placenta and was manually removed</u>		
Physical Examination..... <u>Weak, mild abd. dist, Puffy face, edema (LL-edema), moderately pale</u>		
Provisional/Final Diagnosis..... <u>Acute kidney injury 2° Severe preeclampsia</u>		
Investigations..... <u>HB 6.5g/dL</u>		
Treatment given prior referral..... <u>Tab. Methyl dopa, T. Nifedipine, MgSO₄ loading + maintenance dose</u>		
Reason (s) for referral..... <u>For further management & investigation and possible dialysis</u>		
Vital signs prior referral..... <u>B</u>		

BP	PR	RR	SPO ₂	TEMP	RBG	GCS/AVPU (Alert, Verbal response, Pain response, Unresponsive)	TIME
<u>94/51</u>	<u>89</u>	<u>22</u>	<u>97% RA</u>	<u>36°C</u>	<u>4.1 mmol/L</u>	<u>1/15</u>	<u>12:37AM</u>

Referral Personnel..... DR JAMES KULWA Designation..... M.D Signature..... [Signature] 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

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.....	