KMC REFERRAL PAPER

TO: _____.

Name of Referring Health Unit_____

PATIENT INFORMATION

Name of Mother: _____Sex of baby: _____

Date of Birth_____ Mode of Delivery _____ Birth Weight _____grams

Place of Delivery_____

Address/Village/T.A._____

History: _____

_____

Physical Assessment: _____

Provisional diagnosis: _____

Treatment Given: _____

Reason for Referral: _____

Position of baby during referral_____

Name of Health provider: _____ Signature _____

Feedback paper from the receiving health facility

TO: _____ PHCU.

Name of sending Health facility_____

PATIENT INFORMATION
Name of Mother: _____Sex of baby: _____

Date of Birth:_____ Birth Weight : _____grams
History: _____

_____

Diagnosis: _____
Treatment given and other measure taken:
_____

Name of Health provider: _____ Signature _____