Nodding Syndrome Alliance (NSA)

REFERRAL FORM

(Adapted from Form RSS-MOH-604E)

Referral Form Serial No.		

Part A: Referral Details

County:	Payam:	Boma:	Village:
Date of referral:			
Referred to (*Health Facility*):			
Name of BHW/HHP/CHV referring:			
Contact Telephone of BHW/HHP/CHV			
Signature of BHW/HHP/CHV:			

Name of patient/client: -- **Household Number:** _ _ _/ _ _ _/ _ _ _/_ _ _/_ _ _		**Gender (tick):** ☐**Male** ☐**Female**	**Age:** ________________
Patient/client type *(Tick)*	☐New-born	☐ Child	☐ Adult (> 18 years)

	Reasons for Referral *(Please tick reasons for referral)*			
Suspected epilepsy	☐ Unusually sleepy or unconscious	☐ Convulsions / seizures / fits	☐ Head nodding	
Maternal and new-born health referral	☐ Referred due to acute malnutrition ☐ Referred due to new-born danger signs ☐ Antepartum complications ☐ Referred due to postpartum complications ☐ Other reason (Specify)____			
Child health and nutrition referral	☐ Malaria		☐ Pneumonia	
	☐ Diarrhoea	☐ Routine Immunization	☐ MUAC Yellow	☐ MUAC Red
Other referral (Specify)	☐ Others reason for referral		Specify other reason:	

REFERRAL-FEEDBACK FORM

-------✂-------receiving facility - tear off when making **back referral**--------------✂-------- **Second Copy**

<table>
<tr><td colspan="6">Part B: Please fill out this part and ask the client to return it to the referring BHW/HHP/CHV at next visit</td></tr>
<tr><td>Return/ referral health facility:</td><td colspan="2"></td><td colspan="3">Tel No.</td></tr>
<tr><td rowspan="2">Reply from (person completing form)</td><td colspan="3">Name:</td><td colspan="2">Date:</td></tr>
<tr><td colspan="2">Position/Title</td><td colspan="3">Specialty:</td></tr>
<tr><td colspan="6">To BHW / HHP / CHV</td></tr>
<tr><td>Client Name</td><td colspan="5"></td></tr>
<tr><td>Identity Number</td><td></td><td>Age:</td><td>Sex:</td><td>M</td><td>F</td></tr>
<tr><td>Client address (village/boma)</td><td colspan="5"></td></tr>
<tr><td colspan="4">This client was seen by: (Give name and specialty)</td><td colspan="2">On (date):</td></tr>
<tr><td>Patient history</td><td colspan="5"></td></tr>
<tr><td>Special investigations and findings if any</td><td colspan="5"></td></tr>
<tr><td>Diagnosis</td><td colspan="5"></td></tr>
<tr><td>Procedure / operation</td><td colspan="5"></td></tr>
<tr><td>Medication prescribed</td><td colspan="5"></td></tr>
<tr><td>Date for follow up: (meds, follow-up care)</td><td colspan="5"></td></tr>
<tr><td>Refer back to (BHW/HHP/CHV details):</td><td colspan="3"></td><td colspan="2">On (date):</td></tr>
<tr><td>Referred back by (name, sign & date)</td><td>Name:</td><td colspan="2">Signature:</td><td colspan="2">Date:</td></tr>
</table>