



**Nodding Syndrome Alliance (NSA)**



**REFERRAL FORM**







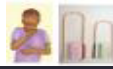


*(Adapted from Form RSS-MOH-604E)*

Referral Form Serial No.	
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**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:			

<b>Name of patient/client:</b> -----	<b>Gender (tick):</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Age:</b> _____
<b>Household Number:</b> _ _ _ / _ _ _ / _ _ _ / _ _ _		
<b>Patient/client type (Tick)</b>	<input type="checkbox"/> New-born 	<input type="checkbox"/> Child 
<input type="checkbox"/> Adult (> 18 years)		

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

## REFERRAL-FEEDBACK FORM

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

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