



Insert MOH Logo

Country, Event, Year

## Patient Referral Form

Date: dd/mm/yyyy

Referral to: Name of facility or service

Focal point: Full name

Phone: + country - area - phone number

Location: Address/Site/District

Email: example@who.int

Referring from: Name of facility or service

Focal point: Full name

Phone: + country - area - phone number

Location: Address/Site/District

Email: example@who.int

### Patient Information

Full Name		Phone	+ <u>country</u> - <u>area</u> - <u>phone number</u>
Date of birth	<u>dd/mm/yyyy</u>	Gender	
Address of discharge destination (if known)			
Accompanied by care provider	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Primary Diagnoses:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Other Diagnoses:

\_\_\_\_\_

\_\_\_\_\_

Treatments initiated:

- \_\_\_\_\_  Ongoing
- \_\_\_\_\_  Ongoing
- \_\_\_\_\_  Ongoing
- \_\_\_\_\_  Ongoing
- \_\_\_\_\_  Ongoing
- \_\_\_\_\_  Ongoing

\*Please attach copy of medication chart at discharge **or** list of current medications (including dose and time of last dose)

For questions regarding referrals, please contact *Insert Name* at ##-###-####.

Reason for referral:  Inpatient  Outpatient  Community

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Transportation needs: Transfer requirements, special considerations, frequency

Follow-up requirements Such as date of surgical review, removal of cast, or removal of external fixator

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**Functional Status**

Mobility  Bed bound  Wheelchair  Crutches  Walking frame  Requires assistance  Independent

Precautions: Such as weight bearing restrictions or spinal precautions

Self-care  Carer dependent  Requires commode  Requires modified latrine/washroom  Independent

Cognitive impairment  No  Yes

Assistive device(s) provided: \_\_\_\_\_

Assistive device(s) required: \_\_\_\_\_

Compiled by: \_\_\_\_\_

Signature: \_\_\_\_\_

Position: \_\_\_\_\_

**NOTE: This form must accompany the patient's medical file and a copy of the form should be retained by the referring team.**

END OF REFERRAL FORM

DRAFT

For questions regarding referrals, please contact *Insert Name* at ##-###-####.