Insert MOH Logo

World Health Organization

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	+ country - area - phone number
Date of birth	dd/mm/yyyy	Gender	
Address of discharge destination (if known)			
Accompanied by care provider ☐ Yes ☐ 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

Transportation needs: Transfer requirements, special considerations, frequency

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

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 devices(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**

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

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