

## TOOL B

SECTION A: Patient /Client Data	
Date:	Time of referral:
Name of the patient:	
Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	Age
Date of birth	
Occupation	
Next of kin	Next of kin contacts
Name of Community Health Unit:	
Name of Link Health Facility:	
Reason(s) for Referral	
Main problem(s):	
Treatment given:	
Comments:	
CHV Referring the Patient:	
Name:	Mobile No:
Village/Estate:	Sub Location:
Location:	
Name of the community health unit:	
SECTION B	
Receiving Officer:	
Date:	Time:
Name of the officer:	
Profession:	
Name of the Health facility:	
Action taken:	
SECTION B: Referral back to the Community	
Name of the officer:	Mobile No:
Name of CHV:	Mobile No:
Name of the community unit:	
Call made by referring officer:	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Kindly do the following to the patient:	
1.	
2.	
3.	

Official Rubber Stamp &amp; Signature