REPUBLIC OF KENYA
MINISTRY OF HEALTH
TOOL X: COMMUNITY REFERRAL FORM

SECTION A: Patient /Client Data	
Date:	Time of referral:
Name of the patient:	
Sex: Male ☐ Female ☐	Age:
Name of village:	
Reason(s) for Referral	
Main problem(s):	
Treatment given:	
Comments:	
CHV Referring the Patient:	
Name of the CHV:	Mobile No:
Village/Estate:	Sub Location:
Location:	Ward:
Name of the community unit:	
Name of Link Health Facility:	
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 Health unit:	
Call made by referring officer: Yes: ☐ No: ☐	
Kindly do the following to the patient: 1. 2. 3.	

Official Rubber Stamp & Signature ____