MINISTRY OF HEALTH
COVID-19 REFERRAL FORM FOR FACILITIES

REFERRAL DETAILS						
COVID-19 status	☐ Confirmed Case			☐ Suspect		
COVID-19 severity	☐ Asymptomatic	☐ Mild	☐ Moderate	☐ Severe	☐ Critical	
Reason for referral						
REFERRING FACILITY	Referring Facility:		Ward/Unit:			
	Referring Clinician:		Phone:		Designation:	
RECEIVING FACILITY	Receiving Facility:		Ward/unit:			
	Receiving Clinician:		Phone:		Designation:	

PATIENT DETAILS						
Name				Age		
Address		Sex	F	M	Phone	
Next of kin		Phone:				

HISTORY			
Chronic conditions/PMH			
Social History (Tick)	Smoking:	Alcohol intake:	Illicit Drug use:
Occupation:			
Chronic medications Specify: drug, dose, frequency, duration			
Allergies (tick)	Medications:	Food:	
History of current illness	Admission date to current facility		
Presenting complaint and History			

EXAMINATION	General:		**KEY SYSTEMIC EXAM FINDINGS:**
Vital signs progress	ARRIVAL	CURRENT	
Respiratory rate (RR)			
Oxygen saturation (SPO2)			
Pulse rate (PR)			
Blood Pressure (BP)			
Blood glucose (RBG)			
AVPU (Alert, to Pain, to Verbal, Unresponsive)			
INVESTIGATIONS SUMMARY: Attach results			

CURRENT MANAGEMENT			
Medications (what, start date, dosage, freq)		Oxygen (Amount & Delivery method)	
FOR INTUBATED CASES (additional notes can be attached)	Ventilator settings: Mode: VT: RR: FiO2: PEEP:		

FURTHER PLAN

Referring Clinician Signature		**Date**	