DSV Blue Referral Form

Client ID:	
Client name:	
Client's Head of household:	
Client's Subcounty:	
Client's Parish:	
Client's Village	
Drug Shop ID (DSID):	Drug Shop Vendor ID (DSVID):
Name of Drug Shop Vendor (DSV):	
Date of referral:	Time of referral:
Age of client:	Temp:
Quick Malaria Test result (circle): 1. Positive 2. Negative 3. Not tested	
Pre-referral treatment given by CMD or parents (Circle)?	
NO	Yes – Coartem Yes – Rectal Artesunate Yes – Other (*specify)*

Reasons For Referral:	✓
Fever in babies less than 4 months old	
Fever that has lasted more than 7 days	
Vomiting and diarrhoea	
Blood in faeces or urine	
Pain when passing urine, or frequent urination	
Wound or Burns	
Skin abscess	
Painful swellings or lumps in the skin	
Ear infection (runny ear or child pulling at ear)	
Sticky or red eyes	
Any other symptoms? Describe:	

REFERRAL DETAILS - TO BE COMPLETED AT HEALTH FACILITY		
Name of Health Facility:	Sub-county:	Date seen: Time seen:
Name of attendant:	Position of attendant:	
Signs and Symptoms recorded:	Diagnostic tests done: YES NO *If no, specify why:*	
Management of patient		
Diagnosis:	Patient Admitted: YES NO	Treatment given:
Final Outcome		
	Date:	
Referred: YES NO		*If referred, referred to:*
Discharged: YES NO		
Died: YES NO		