CMD Emergency Referral Form

Patient Registration no:	
Patient name:	
Name of Head of household:	
Village name:	
Parish:	
Name of CMD:	
Date of referral:	Time of referral:
Age of child:	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 Emergency Referral:	✓
Illness in child below 2 months of age	
Convulsions or fits now or within the past 2 days	
Coma / Loss of consciousness	
Patient is confused or very sleepy - cannot be woken	
Extreme weakness – unable to stand or sit without support	
Very Hot – with temperature of 38.5 or more	
Very Cold – with temperature of 35.0 or less	
Vomiting everything - cannot keep down food or drink	
Not able to drink or breastfeed	
Severe anaemia – very pale palms, fingernails, eyelids	
Yellow eyes	
Difficulty in breathing	
Severe dehydration	
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:	*If referred, referred to:*
Referred: YES NO		
Discharged: YES NO		
Died: YES NO		