Blue form: RDT villages

CMD 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 Referral:	✓
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	
Fever in babies less than 4 months old	

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		