

# DSV Emergency Red Referral Form

Client ID:		<b>Reasons For Emergency Referral:</b>		✓
Client name:		Illness in child below 2 months of age		
Client's Head of household:		Convulsions or fits now or within the past 2 days		
Client's Subcounty name:		Coma / Loss of consciousness		
Client's Parish name:		Client is confused or very sleepy - cannot be woken		
Clients Village name:		Extreme weakness – unable to stand or sit without support		
Drug Shop ID (DSID):	Drug Shop Vendor ID (DSVID):	Very Hot – with temperature of 38.5 or more		
Name of Drug Shop Vendor (DSV):		Very Cold – with temperature of 35.0 or less		
Date of referral:	Time of referral:	Vomiting everything - cannot keep down food or drink		
Age of client:	Temp:	Not able to drink or breastfeed		
Quick Malaria Test result (circle): 1. Positive    2. Negative    3. Not tested		Severe anaemia – very pale palms, fingernails, eyelids		
Pre-referral treatment given by CMD or parents (Circle)?		Yellow eyes		
NO	Yes – Coartem		Difficulty in breathing	
	Yes – Rectal Artesunate		Severe dehydration	
Yes – Other ( <i>specify</i> )		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 <i>If no, specify why:</i>	
Management of patient				
Diagnosis:		Patient Admitted: YES      NO		Treatment given:
Final Outcome				
			Date:	
Referred:	YES	NO	<i>If referred, referred to:</i>	
Discharged:	YES	NO		
Died:	YES	NO		