World Health Organization

Acute Referral Form

A copy of this completed form should be sent to the referral facility.

FOR COMPLETION BY THE INITIATING FACILITY:

Patient Name (LAST, First)		**Date of birth (day-month-year)**		**Sex**	
Patient contact information		**Patient's emergency contact person**	Name: Contact information:		
Initiating facility (refers patient for care)	Name: Focal point: Phone No:	**Reason for referral**	❑Referral facility contacted		
Referral facility (receives patient & provides referral care)	Name: Focal point: Phone No:	**Ambulance**	Name: Focal point: Phone No:		
Date & time of:	Transfer decision / Departure	**Mode of transfer** (circle)	Ground (ambulance)	Air	Sea

Situation

Chief complaint

Primary diagnosis — Pregnant? (circle) Yes / No / unknown

Other acute diagnoses

Treatments initiated

Background

Brief history of present Illness

Relevant past medical & surgical history

ABCDE Conditions	Finding	Intervention
Airway	❑Normal	❑None
Breathing	❑Normal	❑None
Circulation	❑Normal	❑None
Disability (neurologic status)	❑Normal	❑None
Exposure	❑Normal	❑None

Any other significant treatments or procedures

Assessment

Description of what is wrong with the patient & the need for referral. Include current vital signs.

Recommendations

Next steps in treatment plan, including therapies continued during transport:

Potential worsening of patient condition:

Cautions regarding prior therapies or interventions:

Precautions: ❑Highly infectious disease ❑Spinal precautions ❑Weight bearing restrictions ❑Fall risk ❑Aspiration risk ❑Other:

Initiating facility provider	Name:	Signature:

FOR COMPLETION BY THE REFERRAL FACILITY:

Date & time of patient arrival:		**Referral facility provider**	Name: Signature: ❑Feedback provided to initiating facility

Attach copy of medication chart at discharge or list of current medications, including dose & time of last dose.