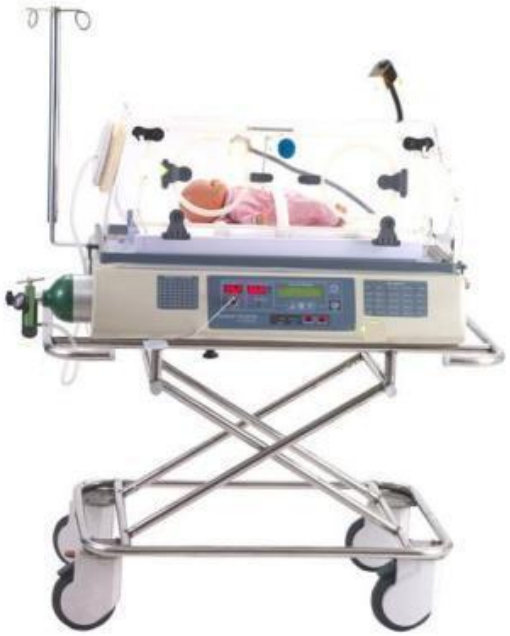
PAEDIATRIC TRANSFER REGISTER



FACILITY NAME: _____

YEAR : _____

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Document on this form every referral consultation (and every hospital contacted)
Follow up monthly on all children – record outcome once discharged or died.

Facility Name:				Year:			Month						
Nº	Name and IP Nº.	Decision to consult: Date, time & MO	Consulted hospital & MO	Consult outcome: Accepted/ Refused	Reason for refusal:		Follow up Consultation:		EMRS phoned Date & time	EMRS arrived: Date & time	EMRS Case Nº	Total time from decision to departure	Date mother trans-ferred
					No Need		Hospital						
					No bed		Date						
					Not stable		Time						
					No Need		Hospital						
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