# Referral note from Health Surveillance Assistant: Sick Child

**Child's First Name:** _____ **Surname** _____ **Age:** __Years/__Months **Boy / Girl**

**Caregiver's name:** _____**Relationship:** Mother / Father / Other: _____

**Physical Address:**_____**Village / TA**_____

| | **The child has** (tick ☐ sign, circle ■ no sign): | **Reason for referral:** | **Treatment given:** |
|---|---|---|---|
| ☐ | ■ Cough? If yes, for how long? __ days | ☐ Cough for 14 days or more | |
| ☐ | ■ Diarrhoea (loose stools)? ____days. | ☐ Diarrhoea for 14 days or more | ☐ Oral Rehydration Salts (ORS) solution for diarrhoea |
| ☐ | ■ If diarrhoea, blood in stool? | ☐ Blood in stool | |
| ☐ | ■ Fever (reported or now)? ____ days. | ☐ Fever for last 7 days | |
| ☐ | ■ Convulsions? | ☐ Convulsions | |
| ☐ | ■ Difficulty drinking or feeding?<br>If yes, not able to drink or feed anything? ☐ ■ | ☐ Not able to drink or feed anything | ☐ LA for fever |
| ☐ | ■ Vomiting? If yes, vomits everything? ☐ ■ | ☐ Vomits everything | ☐ Rectal Artesunate |
| ☐ | ■ Red eyes? If yes, for how long _____days. ■ Difficulty in seeing? If Yes for how long __days | ☐ Red eye for 4 days or more<br>☐ Visual problem | ☐ Antibiotic eye ointment |
| ☐ | ■ Chest indrawing? | ☐ Chest Indrawing | |
| ☐ | **IF COUGH, breaths in 1 minute:** _____bpm<br>■ Fast breathing:<br>☐ Age 2 months up to 12 months: 50 bpm or more<br>☐ Age 12 months up to 5 years: 40 bpm or more | | ☐ Oral antibiotic Amoxicillin for chest indrawing or fast breathing |
| ☐ | ■ Very sleepy or unconscious? | ☐ Very sleepy or unconscious | |
| ☐ | ■ Palmar pallor | ☐ Palmar pallor | |
| | **For child 6 months up to 5 years, MUAC Tape colour:** _____ | ☐ Red on MUAC Tape<br>☐ Yellow on MUAC tape | |
| ☐ | ■ Swelling of both feet? | ☐ Swelling of both feet | |

**Any OTHER PROBLEM** or reason referred:_____

Referred to (name of health facility): _____

Referred by (name of HSA):_____Date: _____ Time: _____

✂ ----------**Cut Here**----------

**FEEDBACK FROM HEALTH FACILITY (Please give feedback)**

Date : ……..……..……..……..…….

Name of the Child :……..**Age**……

Child's identified problem(s) : ……..……..……..……..…….

Treatments given and actions taken : ……..……..……..……..…….

Advice given and to be followed : ……..……..……..……..…….

Name of attending clinician : ……..……..……..…….

Signature : ……..……..……..…….

Name of Health Facility :……..