KENYATTA UNIVERSITY TEACHING, REFERRAL AND RESEARCH HOSPITAL

REFERRAL FORM

CLIENT DETAILS	Name	Gender	IP/OP No.
Address	NHIF No:		
Contact Phone: Email:	Date of Birth	Hospital Referring	
NEXT OF KIN DETAILS	Name	Telephone	
Address			
Phone Number	Email Address		

REFERRAL INFORMATION		
REFERRING FACILITY NAME	Department	
REASON FOR REFERRAL		
TYPE OF REFERRAL	☐ Consultation only ☐ Consultation & short term follow up ☐ Consultation & request to take over care	
PATIENT MEDICAL HISTORY (To be filled by the referring doctor)		

Referring Doctor Name…………………………….Specialty/Designation……………………………………

Signature…………………………….Telephone number……………………………………

Checklist

- ☐ Patient Medical Report
- ☐ Laboratory Investigation Report
- ☐ Radiology Investigation Report

Contacts:

General Referrals (All Services)	**Integrated Molecular Imaging Centred (All Services)**
Phone: 0795 340 216/0794 589 843/0794 896 956	Phone: 0795 340 216/0794 589 843/0794 896 956
Email Address: referral@kutrrh.go.ke	Email Address: referral@kutrrh.go.ke