

REFERRAL SLIP

Name of Clinic: _____
Patient Name: _____
Patient Address: _____
Sex: _____ Age: _____
Treatment Date: _____
Diagnosis: _____
Temporary Treatment: _____
Refer To: _____
For: _____

Vital Signs

<i>Initial Contact</i>	<i>Before Discharge</i>
Temp:	Temp:
BP:	BP:
Pulse:	Pulse:
Resp:	Resp:

Day: _____ Month: _____ Year: _____

Signature: _____

Clinic Physician: _____

Adapted from Reproductive Health Association of Cambodia (RHAC)



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