Referral note from community health worker: Sick Child

Child's name: First __________ Family ______________ **Age:** __Years/___ Months **Boy/Girl**

Caregiver's name:____________________ **Relationship:** Mother/Father/Other: _________

Address, Community: ____

	This child has: Sign present ➔ Tick ☑ **NO** sign ➔ Circle ■	**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	☐ ORS solution for diarrhoea
☐	■ IF DIARRHOEA, blood in stool?	☐ Blood in stool	
☐	■ Fever (reported or now)? since ___ days	☐ Fever for last 7 days or more	☐ Oral antimalarial AL for fever
☐	■ Convulsions?	☐ Convulsions	☐ Rectal artesunate suppository for fever if unable to drink
☐	■ Difficulty drinking or feeding? IF YES, ☐ not able to drink or feed anything?	☐ Not able to drink or feed anything	
☐	■ Vomiting? IF YES, ☐ vomits everything?	☐ Vomits everything	
☐	■ Has HIV?	☐ Has HIV and any other illness	
☐	■ Chest indrawing?	☐ Chest indrawing	
☐	**IF COUGH, count breaths in 1 minute:** _____breaths per minute (bpm) ■ Fast breathing: Age 2 months up to 12 months: 50 bpm or more Age 12 months up to 5 years: 40 bpm or more		☐ Oral antibiotic amoxicillin for chest indrawing or fast breathing
☐	■ Unusually sleepy or unconscious?	☐ Unusually sleepy or unconscious	
	For child 6 months up to 5 years, MUAC strap colour: red__ yellow__ green__	☐ Red on MUAC strap ☐ Yellow on MUAC strap and has HIV	
☐	■ Swelling of both feet?	☐ Swelling of both feet	

Any OTHER reason referred:

❑ TB screening ❑ Vaccines
❑ HIV testing ❑ HIV care and treatment
❑ Other: ____

Referred to (name of health facility): ____

Referred by (name of CHW): __________________________ Date: ___________ Time: _____