Western Cape Government

REFERRAL TO FACILITY FROM COMMUNITY HEALTH WORKER

Name and surname of CHW referring client:	**Name of non-profit organization:** **Contact number of CHW:**

Client details

Client address:	Client name and surname:		
	ID/Date of Birth	Age	Gender
Client contact telephone number			

Child Health	**Women's Health**	**HAST**	**PACK**	**Basic Care**
Neonate 0-28 days	Family planning/ breast screening	TB	HIV	Basic care
Road to Health (child 29 days -5 years)	Cervical cancer/ breast screening	HIV	TB	Injuries
Immunization	Antenatal	STI	COPD/Emphysema	Wound care
Vitamin A	Postnatal care	Medical male circumcision	Asthma	Continence
Deworming			Hypertension	Tracheostomy
Growth monitoring	**Rehabilitation**	**Psychosocial support**	Diabetes	**Nutritional support**
Development	Post-acute care	Adherence support	Epilepsy	Growth Faltering
Oral health		Treatment Literacy	Diarrhea	Low Birth weight
Child feeding		Support Club	**Mental Health**	PEG/ NGT/ NTP
Child with danger signs		Social Group		
		Spiritual support		
		Wellness group		

Provide a brief explanation of the reason for the referral (*Include service client is being referred for if not above and reason for referral)*

TO SERVICE PROVIDER:

Please complete Back-referral Form on the other side of this paper so we can ensure follow-up care.

Signed CHW_____

Signed client_____ Date: _____

Western Cape Government

Back-referral to
Community Health Worker

This client was seen by *(Provider name)*

_____

Facility Name:

_____

Clinic Sticker

Referral outcome								
Referred for	**OUTCOME**			**FOLLOW UP ACTIONS**				
	Problem Solved	**Further intervention Required**	**Outcome not known**	**Self-management**	**Monitoring Progress**	**Keep Scheduled Visits**	**Refer for care**	**Other follow-up action required**
Child Health								
Neonate 0-28 days								
Road to Health (child 29 days -5 years)								
Immunization								
Vitamin A								
Deworming								
Growth monitoring								
Development								
Oral health								
Child feeding								
Child with danger signs								
Women's Health								
Family planning/breast screening								
Cervical screening/breast screening								
Antenatal care								
Postnatal care								
HAST								
TB screening								
HIV screening								
STI screening								
Medical male circumcision								
PACK & Mental Health								
PACK TB								
PACK HIV								
PACK COPD/Emphysema								
PACK Asthma								
PACK Hypertension								
PACK Diabetes								
PACK Epilepsy								
Mental Health								
Diarrhea								
Basic care								
Basic nursing care								
Injuries								
Wound care								
Continence								
Tracheostomy								
Nutritional support: NGT/ PEG								
Psychosocial support								
Adherence support								
Treatment Literacy								

Support Club								
Social Group								
Spiritual support								
Rehabilitation								
Post acute care								

Comment:	
Provider's Signature	Date *(dd/mm/yy)*