GAR/GHS EMERGENCY REFERRAL AND COORDINATION CENTRE

Date(dd/mm/yy):	Time of call: (24hr)	Serial No.:
Health Facility Calling:		District:
Name of staff calling:		Cadre:
Phone number:		

Request Type		
Referral: a) Obstetrics / Gynaecology b) Paediatrics c) Medical d) Surgical	Expert Advice: a) Obstetrics / Gynaecology b) Paediatrics c) Medical d) Surgical	Other Requests:
Reason for request:		
If referral, ambulance needed?	a) Yes	b) No

IMMEDIATE FOLLOW-UP FEEDBACK:

Receiving referral facility: Contact at facility: Time call placed: Time National Ambulance Service called: Time bed secured:			
Feedback to facility initiating call			
Facility 1. Time call placed: 2. Contact at facility:	Bed secured 1. Yes 2. No	Ambulance secured 1. Yes 2. No(reason)	Expert Advice 1. Expert contacted 2. Patient referred

LATE FOLLOW-UP FEEDBACK

Feedback from facility initiating call State of patient on arrival 1. Alive 2. Alive but morbid 3. Dead 4. Unknown Comments:
Comment by Triage Officer on referral process: