THE MEDICAL PRACTITIONERS AND DENTISTS ACT
(Cap. 253)
REFERRAL FORM FOR MEDICAL MANAGEMENT ABROAD

PART A - ***To be filled by the patient***

i. BIO DATA OF THE PATIENT

Surname: ……First name……..……...……..……

Other name(s) ……..……..……..……..……..…

ID/Passport No: ……..……..Date of Birth: ……...……..……

Age:…… Gender: □ Female □ Male

P.O. Box ……..…… Code……..…….. Town ……..…

County……..……

Email address……..……...……..……

Telephone No. …… Mobile No. ……...……...

Source of funding (Tick(✓)where appropriate)

□ Self-funded
□ National Hospital Insurance Fund
□ Private Insurance
□ Government sponsored
□ Other, specify

……
……

ii. DETAILS OF THE NEXT OF KIN

Surname: …… First Name: ……..……..……..…..

Other name(s): ……..……...….

ID/Passport No: ……..…. Date of Birth: ……..……..……

Relationship……...……..……

P.O. Box……..……...… Code…… Town……..……..……

County……..……...……..……

Email address.……..……..……

Telephone No……..…… Mobile No…….……

iii. DETAILS OF THE ACCOMPANYING CARE-GIVER *(If different from B above)*

Surname: …….…….. First Name: ……..……

Other name(s):…….……..……

ID/Passport No: ……..……..…Date of Birth: ……..……..……

Relationship……...……

P.O. Box……..… Code……..……...…Town…….……...……

County……...…….……

Email address ……...……...……..……..……

Telephone No…… Mobile No……..……..……..……

iv. DETAILS OF THE DONOR *(Where Appropriate)*

Surname: …….……..…. First Name: ……..……

Other name(s): …….…….....……..

ID/Passport No: ……..……Date of Birth: ……..……

Relationship……..……..……

P.O. Box…….…….... Code……..…...Town……...……...……

County……

Email address ……..…...…..……..……

Telephone No…… Mobile No……...……..……

v. DECLARATION

I …… hereby declare that the information given above is true to the best of my knowledge and belief.

Signature:……

Date ……

PART B – TO BE FILLED IN BY THE REFERRING PRACTITIONER

i. MEDICAL DETAILS OF THE PATIENT

(1)Provisional diagnosis

……..……

……..……

……..……

(2) Reason for referral:

……..……..……

……..……..……..

(3)Expected Treatment

……..……

……..……

……..……..……

(4)Expected Outcome

……..……

……..……..

(5)Plan for review and follow-up upon return of the patient to the country

……..……

……..……...

ii. DETAILS OF THE RECEIVING FACILITY/PRACTITIONER

a. Receiving Facility

Name of facility*:*

……..……..……

……..……..……

City: ……..…… Country*:* ……

Physical address:

……..……..……

……..……..……..

Postal address:

……..……..……

……..……..……..

E-Mail:……..……..

Telephone/Mobile No……..……..…….

b. Practitioner/Contact Person:

Name:……..……..……..

Qualification:……..……..……

E-mail address……..……..……

Telephone/Mobile No……...……...……

iii. CERTIFICATION BY THE REFERRING PRACTITIONER

Details of referring practitioner:

Surname: ……..…… First Name: ……..…….

Other name(s):……..……...……..

Qualification:

Specialty……..……..……

Sub-specialty……..……..……..

Reg. No:……..……. License No:……..……

P.O. Box……..……..Code……..……Town……..……

County……...……...

Email address……..……..……

Telephone No……..…… Mobile No……...……

Declaration

I, Dr. /Prof.....

(Full Names in Block Letters)

certify that the information given in Part A and B regarding Mr/Mrs/Ms/Mst……is true to the best of my knowledge and belief.

Official Stamp of the hospital

Signature: ……..…….

Date……..……

PART C- To be filled in by the Kenya Medical Practitioners and Dentists Board

I wish to confirm that Dr. /Prof. …….. is registered under Registration Number……., validly retained under current Retention No:……..and is of good standing.

Official Stamp of the Board

Name…….....……Signature……Date……..……

Chief Executive Officer

Kenya Medical Practitioners and Dentists Board

PART D - To be filled in by the Director of Medical Services

Approval is hereby given for..... who has been referred by Dr./Prof.....to travel abroad for medical/dental management in..... (country).

Official Stamp of the Ministry of Health

Name…….……...…Signature……Date……

Director of Medical Services