



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

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.....
.....

(2) Reason for referral:

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.....

(3)*Expected Treatment*

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.....
.....

(4)*Expected Outcome*

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.....

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

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.....

ii. DETAILS OF THE RECEIVING FACILITY/PRACTITIONER

a. Receiving Facility

Name of facility:

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.....

City: Country:

Physical address:

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.....

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.

Signature:

Date.....

<i>Official Stamp of the hospital</i>

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.

<i>Official Stamp of the Board</i>

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).

<i>Official Stamp of the Ministry of Health</i>

Name.....Signature.....Date.....

Director of Medical Services