- **Referring Facility :** Please fill out Part A and ask client to take it to the receiving Facility.
- Please fill out one form as per service needed.
- **If referring for MNCH and FP services attached respective case sheet (UPHC - IMNCI and OBGY Case sheet, Secondary and Tertiary - Newborn, Pediatric and OBGY case sheets used) and/or fill detailed clinical summary on space earmarked on back side of FRF.**
- **Receiving Facility :** Please fill out Part B and either return it directly to the referring Facility or ask the client to return it to the referring Facility at next visit.
- **Part C :** Back Referral Information to be filled up on completing back referral by referring/originating Facility.
- **For Counter referral :** Only section A and B to be filled and respective UPHC informed by phone.

Facility Referral Form (FRF)

Patient Copy

Type of Referral Initiated Referral ☐ Counter referral ☐

Part A: Referral Slip: To be filled out by the Facility making the referral (referring Facility)

Name of Referring Facility :	Type of Referring Facility : UPHC ☐ CD ☐ MH ☐ CHC ☐ CH ☐ District Hospital ☐
OPD/IPD No :	Name of Asha and Ward No.:
Name of the Patient :	Age : / Sex : M / F
Husband/Father :	Mobile No :
Full Address (With Ward Number)	
Date and Time of Admission- Date :..... Time ..... (AM/PM)	Date and Time of Referral -Date : ..... Time ..... (AM/PM)
Referred To Facility Name and Doctor detail (if available)	

Reason for Referral (Give Details)

Category of referral	Maternal (OBGY) ☐	Neonatal ☐	Child ☐	Family Planning ☐	Other ☐

Maternal(OBGY) - Complication Management ☐ C –Section ☐ Assisted Delivery ☐ Normal Delivery ☐ Investigations ☐ **Neonatal -** Sepsis ☐ Premature ☐ Birth Asphyxia ☐ Investigations ☐ **Children -** Pneumonia ☐ Diarrhea ☐ SAM ☐ Investigations ☐ **Family Planning -** Sterilization ☐ IUCD ☐ Antra ☐ Chanya ☐ **Other -**	Describe others clinical condition for referral :
Couse of Referral Services Needed /Notes	

Inter facility Communication and Transfer : (Please check all that apply)

Transferred in Ambulance ☐	Communicated by Phone ☐	No prior communication ☐	
Name of Person who informed about referral -			
Signature of Patient / Relative (Name.....)	Facility Stamp		

Part B : Services Provided : To be filled by receiving facility providing service /fulfilling referral

Name of Facility	
Date when referral services provided	
Services Provided (Details of Services Provided)	
Follow–up needed : Yes ☐/ No ☐, Describe with date	
Additional Comments by Provider	
Signature and Name, Designation of Service Provider	

Part C : Referral Completion : To be filled by Originating Facility

Name of Facility			
Date of Beneficiary reported back to this facility (DD MM YYYY)			
Ask Beneficiary to rate service provided at referred facility		Very good ☐ Good ☐ Need improvement ☐	
Was transport provided for drop back	Yes ☐ No ☐	Accompanied by some one	ASHA ☐ ANM ☐ Other .....
Additional Comments by Provider (including beneficiary feedback for improvement)			
Signature and Name of Service Provider			

Office of Chief Medical & Health Officer District Indore (M.P.)

Facility Referral Form (FRF)

Facility Copy for Referred Facility

Type of Referral Initiated	Referral ☐	Counter referral ☐

Part A: Referral Slip: To be filled out by the Facility making the referral (referring Facility)

Name of Referring Facility :	Type of Referring Facility : UPHC ☐ CD ☐ MH ☐ CHC ☐ CH ☐ District Hospital ☐
OPD/IPD No :	Name of Asha and Ward No.:
Name of the Patient :	Age : / Sex : M / F
Husband/Father :	Mobile No :
Full Address (With Ward Number)	
Date and Time of Admission - Date :..... Time ..... (AM/PM)	Date and Time of Referral - Date : ..... Time ..... (AM/PM)
Referred To Facility Name and Doctor detail (if available)	

Reason for Referral (Give Details)

Category of referral	Maternal (OBGY) ☐	Neonatal ☐	Child ☐	Family Planning ☐	Other ☐

Maternal(OBGY) - Complication Management ☐ C –Section ☐ Assisted Delivery ☐ Normal Delivery ☐ Investigations ☐

Neonatal - Sepsis ☐ Premature ☐ Birth Asphyxia ☐ Investigations ☐

Children - Pneumonia ☐ Diarrhea ☐ SAM ☐ Investigations ☐

Family Planning - Sterilization ☐ IUCD ☐ Antra ☐ Chanya ☐

Other -

Describe others clinical condition for referral :

Couse of Referral Services Needed /Notes	

Inter facility Communication and Transfer : (Please check all that apply)

Transferred in Ambulance ☐	Communicated by Phone ☐	No prior communication ☐	
Name of Person who informed about referral -			
Signature of Patient / Relative (Name.....)	Facility Stamp		

Part B : Services Provided : To be filled by receiving facility providing service /fulfilling referral

Name of Facility	
Date when referral services provided	
Services Provided (Details of Services Provided)	
Follow–up needed : Yes ☐/ No ☐, Describe with date	
Additional Comments by Provider	
Signature and Name, Designation of Service Provider	

Part C : Referral Completion : To be filled by Originating Facility

Name of Facility			
Date of Beneficiary reported back to this facility (DD MM YYYY)			
Ask Beneficiary to rate service provided at referred facility		Very good ☐ Good ☐ Need improvement ☐	
Was transport provided for drop back	Yes ☐ No ☐	Accompanied by some one	ASHA ☐ ANM ☐ Other .....
Additional Comments by Provider (including beneficiary feedback for improvement)			
Signature and Name of Service Provider			

Office of Chief Medical & Health Officer District Indore (M.P.)

Facility Referral Form (FRF)

Copy of Referring facility

Type of Referral Initiated | **Referral** ☐ | **Counter referral** ☐

Part A: Referral Slip: To be filled out by the Facility making the referral (referring Facility)

Name of Referring Facility :	Type of Referring Facility : UPHC ☐ CD ☐ MH ☐ CHC ☐ CH ☐ District Hospital ☐
OPD/IPD No :	Name of Asha and Ward No.:
Name of the Patient : .	Age : / Sex : M / F
Husband/Father :	Mobile No :
Full Address (With Ward Number)	
Date and Time of Admission - Date :..... Time ..... (AM/PM)	Date and Time of Referral - Date : ..... Time ..... (AM/PM)
Referred To Facility Name and Doctor detail (if available)	

Reason for Referral (Give Details)

Category of referral	Maternal (OBGY) ☐	Neonatal ☐	Child ☐	Family Planning ☐	Other ☐

Maternal(OBGY) - Complication Management ☐ C –Section ☐ Assisted Delivery ☐ Normal Delivery ☐ Investigations ☐

Neonatal - Sepsis ☐ Premature ☐ Birth Asphyxia ☐ Investigations ☐

Children - Pneumonia ☐ Diarrhea ☐ SAM ☐ Investigations ☐

Family Planning - Sterilization ☐ IUCD ☐ Antra ☐ Chanya ☐

Other -

Describe others clinical condition for referral :

Couse of Referral Services Needed /Notes	

Inter facility Communication and Transfer : (Please check all that apply)

Transferred in Ambulance ☐	Communicated by Phone ☐	No prior communication ☐	
Name of Person who informed about referral -			
Signature of Patient / Relative (Name.....)	Facility Stamp		

Part B : Services Provided : To be filled by receiving facility providing service /fulfilling referral

Name of Facility	
Date when referral services provided	
Services Provided (Details of Services Provided)	
Follow–up needed : Yes ☐/ No ☐, Describe with date	
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Part C : Referral Completion : To be filled by Originating Facility

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Additional Comments by Provider (including beneficiary feedback for improvement)			
Signature and Name of Service Provider			

Office of Chief Medical & Health Officer District Indore (M.P.)