<table>
<tr><td> </td><td colspan="2">MARIKINA CITY
ADOLESCENT HEALTH AND DEVELOPMENT PROGRAM
REFERRAL FORM
(Referral Facility Copy)</td><td> </td></tr>
<tr><td colspan="2">Date of Referral:</td><td colspan="2">Reference Number:</td></tr>
<tr><td colspan="4">Name of Referring Facility:</td></tr>
<tr><td colspan="4">Address:</td></tr>
<tr><td colspan="4">Telephone number:</td></tr>
<tr><td colspan="4">Name of Service Provider:</td></tr>
<tr><td colspan="4">Name of the Facility where the client is being referred:</td></tr>
<tr><td colspan="3">Name of Client:</td><td rowspan="2">Age:</td></tr>
<tr><td colspan="3">Address:</td></tr>
<tr><td colspan="4">Reason for Referral:</td></tr>
<tr><td colspan="4">Brief History (include pertinent PE and laboratory findings and actions taken, if any)</td></tr>
<tr><td colspan="4">Clinical Impression:</td></tr>
<tr><td colspan="2">Signature of Service Provider</td><td colspan="2">Signature over Printed Name of Parent/Guardian</td></tr>
<tr><td colspan="4">---CUT HERE---</td></tr>
</table>

<table>
<tr><td colspan="2">REFERRAL RETURN SLIP
(Please cut and instruct parent/guardian to return the slip to referring facility)</td></tr>
<tr><td colspan="2">Date:</td></tr>
<tr><td colspan="2">Name of Referral Facility:</td></tr>
<tr><td colspan="2">Telephone number:</td></tr>
<tr><td colspan="2">Name of Service Provider:</td></tr>
<tr><td colspan="2">Final Diagnosis:</td></tr>
<tr><td colspan="2">Recommendations:</td></tr>
<tr><td>Signature of Service Provider</td><td>Signature over Printed Name of Parent/Guardian</td></tr>
</table>