

REFERRAL SUMMARY

SNCU District Hospital.....

Baby of (Mother's Name)		Father's Name :		
SNCU Reg. No.		Sex : M / F	Age :	Weight (Kg) :
Date & Time of Referral/...../20.....	Place of Referral :		
Indication for Referral	Ventilation / Surgical Intervention / Diagnostic Work up / Metabolic Work up / Dialysis / Other			

***Final Diagnosis** (Encircle the most relevant single diagnosis, If multiple causes also mention all relevant numbers in the end as per priority)

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| <ul style="list-style-type: none"> ELBW (999 gm or less) : P 07.0 Other LBW (1000 gm – 2499 gm) : P 07.1 Extreme Immaturity (<28 Weeks) : P 07.2 Prematurity (28-<37 Weeks) : P 07.3 Small for Gestational Age (IUGR) : P 05.1 Neonatal Aspiration of Meconium : P 24.0 RDS of Newborn (HMD) : P 22.0 Transient Tachypnoea of Newborn : P 22.1 Pneumothorax : P 25.1 Congenital Pneumonia : P 23 Acquired Pneumonia : J 15 Primary Sleep Apnoea of Newborn : P 28.3 Birth Asphyxia : P 21.0 HIE of Newborn : P 91.6 Neonatal Sepsis : P 36.9 Meningitis : G 00 | <ul style="list-style-type: none"> Convulsions of Newborn : P 90
(Hypoxic, Hypoglycaemic, Hypocalcaemic, CNS Infections, Birth Trauma, Metabolic, Other, Unknown Cause) Hemolytic disease of Newborn : P 55 Neonatal Jaundice : P 59 Acute Renal Failure : N 17 Neonatal Cardiac Failure : P 29.0 Shock : R 57 DIC : P 60 Intraventricular Hemorrhage : P 52.3 Neonatal Diarrhoea : A 09 Tetanus Neonatorum : A 33 Hypothermia of Newborn : P 80 Environmental Hyperthermia of Newborn : P 81.0 Neonatal Hypoglycaemia : P 70.4 | <ul style="list-style-type: none"> Congenital Malformation :
(a) Cong. Diaphragmatic Hernia : Q 79.0
(b) Cong. Hydrocephalus : Q 03
(c) Meningomyelocele : Q 05
(d) Imperforate anus : Q 42.3
(e) T.O. Fistula : Q 39.2
(f) Congenital Heart Disease : Q 21
(g) Cleft Palate : Q 35
(h) Cleft Lip : Q 36
(I) Cleft Palate with Cleft Lip : Q 37
(j) Congenital Deformities of Hip : Q 65
(k) Congenital Deformities of Feet : Q 66
(l) Other Malformation (.....) Any Other Diagnosis (.....) Multiple Diagnosis-Mention All Relevant Codes :
a b c d |
|--|--|---|

*(Based on WHO, ICD - 10 Version: 2010)

TREATMENT GIVEN

1. Oxygen : Yes / No (If yes duration.....)
2. Phototherapy : Yes / No (If yes duration.....)
3. Antibiotics : Yes / No (If yes fill the details below)

	Name & Dose	No. of Days
a)
b)
c)
d)

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PRESENTING COMPLAINTS & COURSE DURING TREATMENT

RELEVANT INVESTIGATIONS

CONDITION AT TIME OF REFERRAL

TREATMENT ADVISED ON WAY

1. Keep Baby Warm.
2. Take Care of Airway and Breathing.
3. Monitor Color / Heart Rate / Blood Glucose.

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Doctor's Name and Signature