
# REPUBLIC OF NAMIBIA
# Ministry of Health and Social Services

# Referral Counter-Referral Form

**HEP Form 7** **Referral Counter-Referral Form**

**[A] REFERRAL**
**For HEW to fill out and give to the Client / Caregiver to take to the Health Worker**

Date: _____

Referred by HEW (name): _____

Community: _____ HH# _____

Name of Client referred: _____

Date of Birth: _____ Sex: _____

Does the client / caregiver agree to be referred (if YES, client/caregiver signs) _____

Client referred to (facility name) _____

## Referred for/to (tick all that apply)

**First Aid**

□ Broken bones □ Burns □ Bleeding or Wounds □ Bites & Stings □ Poisoning □ Fever/Pain

**Maternal Health**

□ Pregnancy danger signs □ ANC □ Maternal danger signs □ Family Planning

**Neonatal Health**

□ Neonatal danger signs □ Low birth weight □ Breastfeeding complication

**Child Health**

□ Child danger signs □ Cough/difficulty breathing □ Diarrhea □ Fever

□ Immunization □ Malnutrition □ Lice/Scabies/Worms □ Ear/Throat Problems

**HIV/TB/Malaria**

□ HCT □ ARV defaulter □ TB screening/treatment □ TB defaulter □ Malaria suspect

**Social Welfare, Disability and Rehabilitation**

□ Family Violence □ Substance abuse □ Suicidal behavior □ Elder abuse □ Parent/child relationship

□ Social grant □ Rehabilitation (Vision, Hearing/speech, Movement) □ Mental illness □ Assistive device (Vision, Hearing, Movement)

Other (Specify) _____

HEW Signature: _____

*tear or cut here*

**[B] COUNTER-REFERRAL**
**For the Health Worker to fill out and give back to the client who then shares it with the HEW**

Date: _____ Name of Facility _____

Name of Client: _____

Remarks: _____

_____

_____

Service(s) given: _____

Follow up needed by HEW (e.g., home care, revisits): _____

Date of next visit to health facility: _____

Name of Health worker & Signature: _____