



REFERRAL SLIP
(Referring health facility copy)

SR No. _____

Date:Lab referred to:.....
Name of referring HF:
Name of Patient:
Age: years Sex: M / F / TG
Address of patient (with landmarks)
.....
.....
.....

Patient's / Contact person's Mobile number : _____

Kindly tick

- ☐ Cough.....days
☐ Fever.....days
☐ Loss of weightdays
☐ Night sweatdays
☐ Blood in sputum/ coughdays

☐ Contact of TB / MDR TB

NIKSHAY ID. _____

Stamp of HF Referred by (Name & Sign)



REFERRAL SLIP
(Patient copy)

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