THE MEDICAL PRACTITIONERS AND DENTISTS ACT
(Cap. 253)
REFERRAL FORM FOR MEDICAL MANAGEMENT ABROAD

PART A - ***To be filled by the patient***

i. BIO DATA OF THE PATIENT

Surname: ……First name……..……...……...……

Other name(s) ……..……..……..……...…

ID/Passport No: ……..……..Date of Birth: ……..……..……

Age:……. Gender: □ Female □ Male

P.O. Box ……..…… Code……..……..….. Town ……..…

County……..……

Email address……..……...……...……

Telephone No. …… Mobile No. ……..……...

Source of funding (Tick(✓)where appropriate)

□ Self-funded
□ National Hospital Insurance Fund
□ Private Insurance
□ Government sponsored
□ Other, specify

……
……

ii. DETAILS OF THE NEXT OF KIN

Surname: ……. First Name: ……..……..……...…..

Other name(s): ……..……...….

ID/Passport No: ……...…. Date of Birth: ……..……..……

Relationship……...……...…….

P.O. Box……...……...… Code…… Town……..……...……

County……..……...……..……

Email address.……

Telephone No……..…… Mobile No…….……

iii. DETAILS OF THE ACCOMPANYING CARE-GIVER *(If different from B above)*

Surname: ……..…….. First Name: ……..……

Other name(s):……..……..……

ID/Passport No: ……..……..…Date of Birth: ……..……..……

Relationship……...……

P.O. Box……..…. Code……..……...…Town…….……...……

County……...…….……

Email address ……...……...……..……..……

Telephone No…… Mobile No……...……..……..……

iv. DETAILS OF THE DONOR *(Where Appropriate)*

Surname: ……..……..…. First Name: ……..……

Other name(s): ……..…….....……..

ID/Passport No: ……..……Date of Birth: ……..……

Relationship……..……..……

P.O. Box……..…….... Code……..…...Town……...……...……

County……

Email address ……..…...…..……..……

Telephone No…… Mobile No……...……..……

v. DECLARATION

I …… hereby declare that the information given above is true to the best of my knowledge and belief.

Signature:……

Date ……

PART B – TO BE FILLED IN BY THE REFERRING PRACTITIONER

i. MEDICAL DETAILS OF THE PATIENT

(1)Provisional diagnosis

……..……

……..……

……..……

(2) Reason for referral:

……...……..……

……...……..……..

(3)Expected Treatment

……...……

……..……

……...……...……

(4)Expected Outcome

……...…….……

……..……...

(5)Plan for review and follow-up upon return of the patient to the country

……..……

……..……...

ii. DETAILS OF THE RECEIVING FACILITY/PRACTITIONER

a. Receiving Facility

Name of facility*:*

……...……..……

……..……...…….

City: ……..…… Country*:* ……

Physical address:

……...……..……

……..……..……...

Postal address:

……...……..……

……...……..

E-Mail:……..……..……..

Telephone/Mobile No……..……..…….

b. Practitioner/Contact Person:

Name:……..……..……..

Qualification:……..……..……

E-mail address……..……..……

Telephone/Mobile No……...……...……

iii. CERTIFICATION BY THE REFERRING PRACTITIONER

Details of referring practitioner:

Surname: ……..…… First Name: ……..…….

Other name(s):……..……...……..
Qualification:

Specialty……..……..……

Sub-specialty……..……..……..

Reg. No:……..……. License No:……..……

P.O. Box……..……..Code……..……Town……..……

County……...……...

Email address……..……..……

Telephone No……..…… Mobile No……...……

Declaration

I, Dr. /Prof.....

(Full Names in Block Letters)

certify that the information given in Part A and B regarding Mr/Mrs/Ms/Mst……is true to the best of my knowledge and belief.

Official Stamp of the hospital

Signature: ……..…….

Date……..……

PART C- To be filled in by the Kenya Medical Practitioners and Dentists Council

I wish to confirm that Dr. …….. is registered under Registration Number……., validly retained under current Retention No:……..and is of good standing.

Official Stamp of the Board

Name…….....……Signature……Date……..……

Chief Executive Officer

Kenya Medical Practitioners and Dentists Council

PART D - To be filled in by the Director of Medical Services

Approval is hereby given for..... who has been referred by Dr.....to travel abroad for medical/dental management in..... (country).

Official Stamp of the Ministry of Health

Name…….……...…Signature……Date……

Director of Medical Services

Physical Address: MP&DC House- Woodlands Rd off Lenana Rd
Tel: +254 20-272 8752 |+254 20 272 4994 |+254 20 271 1478
Mobile: +254 720 771 478 |+254 738 504 112
Address: P.O Box 44839-00100, NAIROBI-Kenya

Email: patientreferrals@kenyamedicalboard.org

Website: www.medicalboard.co.ke