

**MEDICAL REFERRAL FORM**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_ a.m./p.m.

Where did injury occur? \_\_\_\_\_

How did injury occur? Collision with \_\_\_\_\_

Hit by \_\_\_\_\_ Fell on/from \_\_\_\_\_

Other \_\_\_\_\_

Date of last known tetanus shot: \_\_\_\_\_

Part of body injured (indicated L or R for left or right when applicable):

- |  |                                 |                                |                                   |
|--|---------------------------------|--------------------------------|-----------------------------------|
| <input type="checkbox"/> Ankle                 | <input type="checkbox"/> Eye    | <input type="checkbox"/> Hip   | <input type="checkbox"/> Nose     |
| <input type="checkbox"/> Arm                   | <input type="checkbox"/> Face   | <input type="checkbox"/> Knee  | <input type="checkbox"/> Scalp    |
| <input type="checkbox"/> Back                  | <input type="checkbox"/> Finger | <input type="checkbox"/> Leg   | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> Chest                 | <input type="checkbox"/> Foot   | <input type="checkbox"/> Lip   | <input type="checkbox"/> Stomach  |
| <input type="checkbox"/> Collar Bone           | <input type="checkbox"/> Hand   | <input type="checkbox"/> Mouth | <input type="checkbox"/> Tooth    |
| <input type="checkbox"/> Elbow                 | <input type="checkbox"/> Head   | <input type="checkbox"/> Neck  | <input type="checkbox"/> Wrist    |
| <input type="checkbox"/> Other (specify) _____ |                                 |                                |                                   |

Nursing Intervention/Comments: \_\_\_\_\_

**Illness**

Complaint \_\_\_\_\_

Assessment \_\_\_\_\_

Comments: \_\_\_\_\_

Parent/guardian/Relative Caregiver advised: \_\_\_\_\_ of injury/illness Yes \_\_\_\_\_ No \_\_\_\_\_  
to seek medical attention: Yes \_\_\_\_\_ No \_\_\_\_\_

Signature: \_\_\_\_\_, School Nurse Date: \_\_\_\_\_

Phone: \_\_\_\_\_

**PLEASE COMPLETE AND RETURN TO SCHOOL NURSE:**

Examining Licensed Healthcare Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Treatment: \_\_\_\_\_

Send copy of emergency card if transporting to Emergency Room