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

The Practitioner should immediately send an email indicating that he/she has referred the patient to (Email: patient.referrals@kmpdc.go.ke)

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.

Signature: ……………………….……………………………………….

Date…………………………………………………………….…………

Official Stamp of the hospital

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 Licensed under current

Practice License No:………………………………..and is of good standing.

Official Stamp of the Council

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: KMPDC Office Complex, 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: patient.referrals@kmpdc.go.ke

Website: www.kmpdc.go.ke