ENQUIRY FORM

To THH Child and Adolescent Unit-Sinothando
Tel: 033 341 5500
Fax: 033-3428745
Email: CAU.THH@kznhealth.gov.za

Date: _____

Completed by Dr: _____ Referring Hospital: _____ Ward: _____
Contact details: Cell_____ Hospital tel: _____ Hospital fax: _____
Patient name: _____ Date of Birth: _____ Age: _____ Gender: M/F
Grade: current_____passed _____ School: _____school tel: _____
Address: _____
Name and contact details of family/guardian: _____
Name and contact details of other agencies involved (e.g. social worker): _____
_____
Date of admission to your hospital: ___/____/201__ Admission status: vol. / assist. /invol.
Presenting history and reasons for admission to your hospital: _____
_____
_____
_____
_____
Medical history (include pregnancy, birth, milestones, school) _____
_____
_____
_____
All medication history (include response and side effects):_____
_____
_____
_____
Current MSE and PE: _____
_____
_____
Investigation/ assessment results:
Biological:_____
_____
_____
Psychological:_____
_____
_____
Social:_____
_____
_____
Reason for referral: _____
_____

For official use
ACTION: