FORM 2 (r. 39(2)(a))

Bima Bora, Afya Nyumbani

REPUBLIC OF KENYA
SOCIAL HEALTH INSURANCE ACT, 2023
SOCIAL HEALTH INSURANCE (GENERAL) REGULATIONS, 2024

REFERRAL FOR OVERSEAS TREATMENT

SOCIAL HEALTH AUTHORITY

REFERRAL FOR OVERSEAS TREATMENT FORM

PART A - To be filled by the patient

A. BIODATA OF THE PATIENT

Surname: …… First name……

Other name(s): ……

ID/Passport No: …… SHA Number: ……

Date of Birth: …… Age:…… Gender: F/M: ……

P.O. Box …… Town …… County……

Email address……

Telephone No. …… Mobile No. ……

Source of funding (Tick(✓)where appropriate) :

☐ Self-funded ☐ Social Hospital Insurance ☐ Private Insurance specify

……

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

Surname: …… First name……

Other name(s): ……

ID/Passport No: ……. SHA Number: ……

Date of Birth: ……. Age:…… Gender: F/M: ……

Relationship to the patient: ……

Email address…….

Telephone No. …… Mobile No. ……

C. DETAILS OF THE DONOR (Where Applicable)

Surname: …… First name……

Other name(s): ……

ID/Passport No: ……. SHA Number: ……

Date of Birth: ……. Age:…… Gender: F/M: ……

Relationship to the patient: ……

Email address…….

Telephone No. …… Mobile No. ……

D. PATIENT/ AUTHORIZED PERSON'S 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

E. MEDICAL DETAILS OF THE PATIENT

(1)Provisional diagnosis ……

……

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(2) Reason for referral: ……

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(3)Expected Treatment ……

……

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(4)Expected Outcome ……

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

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F. DETAILS OF THE RECEIVING FACILITY/PRACTITIONER

a. Receiving Facility Name of facility: ……

City: …… Country: …… SHA Healthcare Provider Number: ……

b. Practitioner/Contact Person:

Name:……

Qualification:……

E-mail address……

Telephone/Mobile No……

G. 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……..……

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.

Name…….....…… Signature…… Date…….…… Chief Executive Officer Kenya Medical Practitioners

and Dentists Council Official Stamp of the Council

PART D - To be filled in by the SHA DIRECTOR

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

Name…….…….…. Signature…… Date……