# Community Screening Referral Slip

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| **Name of Child:** |  |
| **Family Name:** |  |
| **Name of Mother/Caregiver:** |  |
| **Place of Origin:** | **Referral Health Facility:** |
| **Date of Community Outreach:** |  |
| **Bilateral Pitting Oedema:** 🞏Yes 🞏No | **MUAC:** mm |
| **Other Findings:** | |
| **Name of Community Outreach Worker:** | **Signature:** |