FORM NO.

UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN

NAME OF HEALTH FACILITY

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SUPERVISOR'S HOSPITAL REPORT FORM

Date…… Time…….. Shift (Morning, Evening, Night)……

Description of serious patient									
DOA	**Ward**	**Bed No.**	**Reg. No**	**Names of patients**	**Age**	**Sex**	**Diagnosis**	**GCS**	**Medical and Nursing management given**	**Pending issues**

Description of Hospital Report and Bed State																	
Ward	**Prev. No of patients**	**New Admission**	**Present No. of Patients**	**Discharge**	**Transfer in**	**Transfer out**	**Referral received**	**Referral Out**	**Absconded**	**DAMA**	**Death**	**Surgeries**		**Number of Staff on Duty**			
												Major	**Minor**	**RN**	**EN**	**DR**	**MAT**
Total																	

Key Info	SVD	C/S	FSB	MSB	Low scores	Neonatal deaths	Total Deliveries	Maternal deaths	Status of Ambulance	Availability of water	Availability of electricity	Staff on Call responded	Official Visitors
No./Status													

Any other event/incidence to report……

Name of the Reporting Supervisor……Name of the Receiving supervisor……