HEAD OFFICE: 8th Floor, The World Center Building
330 Sen. Gil Puyat Ave., Makati City 1200
Trunkline: 884-9999
Fax No.: 810-3855: 848-6454
Website: www.medicardphils.com
Email: inquiry@medicardphils.com

Form No. _____

Out-Patient Consultation Form

This request is valid from _____ until _____

Date of Consullt:

Reference No.

Doctor:

Hospital:

Member Name:

Age:

Gender:

Member ID:

Company:

Remarks:

Effectivity Date:

Validity Date:

Chief Complaint:

History of Present Illness:

Past/Family History:

Review of Systems (ROS):

Vital Signs:

BP: _____ **HR:** _____ **RR:** _____ **Temp:** _____

Physical Examination:

Primary Diagnosis/ Working Impression:

Prescribed Test/s for Primary Diagnosis

Dx Remarks:

Contributory to Chief Complaint:

Prescribed Test/s for Other Diagnosis

Type of illness:

- ☐ **Congenital:**
- ☐ **Maternity Related:**
- ☐ **Medico Legal:**

Plan of Management/Notes:

Procedure(s) Done in Clinic:

Approval No. for Procedure(s) Done in Clinic:

Waiver: Consent is hereby given by the patient or by the next kin (if patient cannot sign) to the disclosure and processing of the patient's medical/health information by MediCard and its representatives, its Medical Service Units/Teams and its Accredited Hospitals/Clinics which is determinative for the assessment of the patient's coverage and necessary for the treatment of his/her illness. MediCard and its representatives are also free to disclose the said information including utilization data of the patient to its concerned Company upon demand of the latter for such other legal purpose it may have including for the proper administration of the Company's health benefits program. MediCard and its representatives, its Medical Service Units/Teams and its Accredited Hospitals/Clinics are hereby released from any liability by reason of such disclosure.

_____ **Signature of Patient/Member**

_____ **Signature of Attending/Physician**