CITY GOVERNMENT OF SAN JUAN
CITY HEALTH DEPARTMENT

REFERRAL SLIP

Referring Health Facility/Contact No. _____

Patient's Name: Last _____ M.I _____ First _____
Address _____
Tel/Mobile No. _____
Parent/Guardian Name _____
Tel/Mobile No. _____

Date/Time _____
Health Card GGG # _____
PhilHealth Member # _____
PhilHealth Category _____
Gender _____
Birthdate _____ Age _____
Birth Place _____
Civil Status _____
Religion _____
Occupation _____

Vital Signs BP _____ PR _____ RR _____
Wt. _____ Temp. _____ Ht. _____
Chief Complaint _____

Initial Diagnosis _____

Management _____

Reason for Referral _____

Referred by: _____
Name/Signature _____
Designation _____
Contact No. _____

(This portion should be cut and be given to the patient. To be filled-out by the Referral Health Facility)

REFERRAL – RETURN SLIP

Referring Health Facility _____ From _____
Patient's Name _____ Date/Time _____
Final Diagnosis _____

Management: (Including medications, diagnostic procedures, definitive procedures)

Physician: _____
Name/Signature: _____
Lic. No.: _____
Date: _____
Contact No.: _____