Annex 4.0 Recommended Templates
4.1. Clinical Abstract/Consultation Summary Template

Name of Physician:			Date & Time of Teleconsultation:		
Name and Address of Health Facility (if applicable):			Name of Telemedicine Partner (if applicable): If none, indicate telemedicine platform being used:		
Prior to teleconsultation proper, obtain patient consent: ( ) Yes ( ) No Is patient accompanied/assisted by another person during the consultation: ( ) Yes ( ) No					
A. DEMOGRAPHIC PROFILE					
1. Patient Profile			**Case #**		
Last Name	First Name	Middle Name	Birthdate (yyyy-mm-dd)	Age	Sex
Occupation	Civil Status	Nationality	PhilHealth No.	Passport No.	
Name of Companion: (if patient is assisted/accompanied during the teleconsultation)			Relationship:	Phone No.	
2. Philippine Residence					
House No./Lot/Bldg.	Street	Municipality/City	Province		
Region	Home Phone No.	Cellphone No.	Email address		
B. CLINICAL HISTORY AND PHYSICAL EXAMINATION					
3. Clinical History					
Reason for Consultation					
Date of Onset of Illness	Name of Referral Health Facility (if applicable)	Date of Referral (if applicable)			
Known Medical Condition/s and Medical History					
Current Medications			Blood Type		
4. Physical Examination (Inspection)					
Clinical Status at the time of Consult					
Specific Findings					
C. COVID-19 SCREENING					
5. Overseas Employment Address (for Overseas Filipino Workers)					
Employer's Name:			Place of Work:		
House #/Bldg. Name	Street	City/Municipality	Province/State		
Country	Office Phone No.	Cellphone No.			
6. Travel History					

History of travel/visit/work in other countries with known COVID-19 transmission14 days prior to onset of signs and symptoms: ( ) Yes ( ) No		Port of exit:	
Airline/Sea vessel:	Flight/Vessel Number	Date of Departure	Date of Arrival in Philippines:

7. Exposure History	
Known COVID-19 Case: ( ) Yes ( ) No ( ) Unknown	If yes: Date of Contact with Known COVID-19 Case:
Accommodation ( ) Yes ( ) No ( ) Unknown Specify type: Address:	Date of Last Exposure: Name: ( ) Guest ( ) Hotel worker
Food Establishment ( ) Yes ( ) No ( ) Unknown Specify type: Address:	Date of Last Exposure: Name: ( ) Diner ( ) Crew
Store ( ) Yes ( ) No ( ) Unknown Specify type: Address:	Date of Last Exposure: Name: ( ) Customer ( ) Worker
Health Facility ( ) Yes ( ) No ( ) Unknown Specify type: Address: Significant Other	Date of Last Exposure: Name: ( ) Patient ( ) Health Worker ( )
Event ( ) Yes ( ) No ( ) Unknown Specify type:	Date of Last Exposure: Event Place:
Workplace ( ) Yes ( ) No ( ) Unknown Company Name:	Date of Last Exposure: Address:
List of names of persons in contact with during any of this occasion, and their contact numbers:	

8. Clinical Assessment		
Symptomatic: A. 14 days PRIOR to first date of exposure ( ) Yes ( ) No B. Anytime during date of exposure ( ) Yes ( ) No	If yes, date of onset of illness: Name of referral health facility: Date of referral:	If no, place of quarantine: ( ) Home ( ) Quarantine Facility: _____

Fever _____°C	Cough ( )	Colds ( )	Sore throat ( )	Diarrhea ( )	Shortness/ difficulty of breathing ( )

Other symptoms, specify	Is there any history of other illness? ( ) Yes ( ) No If YES, specify: _____
Chest X-Ray done? ( ) Yes ( ) No If yes, when? _____	Are you pregnant? ( ) Yes LMP _____ ( ) No
CXR Results: Pneumonia ( ) Yes ( ) No ( ) Pending	Other Radiologic Findings:

9. Specimen Information					
Specimen Collected	If YES, Date Collected	Date sent to RITM or any accredited laboratory	Date received in RITM	Virus Isolation Result	RT-PCR Result

			or any accredited laboratory		
( ) Serum	___/___/___	___/___/___	___/___/___		
( ) Oropharyngeal/ Nasopharyngeal swab	___/___/___	___/___/___	___/___/___		
( ) Others	___/___/___	___/___/___	___/___/___		

10. Classification

□ Suspect Case □ Probable Case □ Confirmed Case

11. Outcome

Date of Discharge:	Condition on Discharge: ( ) Died ( ) Improved ( ) Recovered ( ) Transferred ( ) Absconded

D. DIAGNOSIS/ASSESSMENT

Summary of Assessment Findings

Diagnosis

Clinical Classification: ( ) COVID-19 Case ( ) Non-COVID-19 Case
If COVID-19 Case, ( ) Suspected Case ( ) Probable Case ( ) Confirmed Case

E. PLAN OF MANAGEMENT

Plan of Management:

Prescription:

Referral:

Disposition:

Name & Digital Signature of Physician:	**License #**	**Professional Tax Receipt (if applicable):**

COVID-19 Case Classification

1. **Suspect case** – is a person who is presenting with any of the conditions below.
   a. All Severe Acute Respiratory Infection (SARI) cases where NO other etiology fully explains the clinical presentation.
   b. Influenza-Like Illness (ILI) cases with any one of the following:
      i. with no other etiology that fully explains the clinical presentation AND a history of travel to or residence in an area that reported local transmission of COVID-19 disease during the 14 days prior to symptom onset OR
      ii. with contact to a confirmed or probable case of COVID-19 in the two days prior to onset of illness of the probable/confirmed COVID-19 case until the time the probable/confirmed COVID-19 case became negative on repeat testing.
   c. Individuals with fever or cough or shortness of breath or other respiratory signs or symptoms fulfilling any one of the following conditions:
      i. Aged 60 years and above
      ii. With a comorbidity
      iii. Assessed as having a high-risk pregnancy
      iv. Health worker

2. **Probable case** – a suspect case who fulfills anyone of the following listed below.
   a. Suspect case whom testing for COVID-19 is inconclusive
   b. Suspect who tested positive for COVID-19 but whose test was not conducted in a national or subnational reference laboratory or officially accredited laboratory for COVID-19 confirmatory testing

3. **Confirmed case** – any individual, irrespective of presence or absence of clinical signs and symptoms, who was laboratory confirmed for COVID-19 in a test conducted at the national reference laboratory, a subnational reference laboratory, and/or DOH-certified laboratory testing facility.