CITY GOVERNMENT OF SAN JUAN
CITY HEALTH DEPARTMENT

REFERRAL SLIP

Referring Health Facility/Contact No. _____

	Last	M.I	First		
Patient's Name				Date/Time	
Address				Health Card GGG #	
				PhilHealth Member #	
				PhilHealth Category	
				Gender	
Tel/Mobile No.				Birthdate	Age
Parent/Guardian Name				Birth Place	
Tel/Mobile No.				Civil Status	

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.: