PhilHealth
Your Partner In Health

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CF4

(Claim Form 4)
August 2018

Series # | | | | | | | | | | | | |

IMPORTANT REMINDERS:

PLEASE FILL OUT APPROPRIATE FIELDS. WRITE IN CAPITAL LETTERS AND CHECK THE APPROPRIATE BOXES.

This form, together with other supporting documents, should be filed within **sixty (60) calendar days** from date of discharge.

All information, fields and tick boxes in this form are necessary. **Claim forms with incomplete information shall not be processed.**

FALSE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMISITRATIVE LIABILITIES.

I - HEALTH CARE INSTITUTION (HCI) INFORMATION

1. Name of HCI
Southern Philippines Medical Center

2. Accreditation Number
H 1 1 0 1 8 3 1 9

3. Address of HCI

Bldg No. and Name/Lot/Block	Street/Subdivision/Village	Barangay/City/ Municipality	Province	Zip Code
J.P Laurel, Bajada		Davao City	Davao del Norte	8000

II - PATIENT'S DATA

1. Name of Patient

Last Name	First Name	Middle Name
SANCHEZ	MYRA	CRUZ

2. PIN

3. Age
20 year(s) 2 month(s)

4. Sex
[ ] Male [/] Female

5. Chief Complaint
- sjnzjz

6. Admitting Diagnosis
ajsjjssjajjss

7. Discharge Diagnosis
dfsd sdfs sdfsdfsdbsjs

8.a. 1st Case Rate Code

8.b. 2nd Case Rate Code

9.a. Date Admitted: 0 9 (month) – 2 7 (day) – 2 0 1 9 (year)

9.b. Time Admitted 0 7 (hour) : 4 2 (min) [/] AM [ ] PM

10.a. Date Discharged: 0 0 (month) – 0 0 (day) – 0 0 0 0 (year)

10.b. Time Discharged 0 0 (hour) : 0 0 (min) [ ] AM [ ] PM

III - REASON FOR ADMISSION

1. History of Present Illness:

Nice Wany

2.a. Pertinent Past Medical History:

Past Medical History: Cerebrovascular Disease-Ay.
Surgery: Ar (2019-10-14), A (2019-10-15).
Family History: Urinary Tract Infection-Ay.
Social History: Years of smoking, 0. Average Stick per day, 1. Average Stick per year, 0.1. Non-alcoholic drinker. A drug user.
Immunization: Child Immunization, DPT2. Adult Immunization, MMR. Elderly Immunization, Pnuemococcal Vaccine.

2.b. OB/GYN History

G 1 **P** 1 **(** 0 **-** 0 **-** 1 **-** 1 **) LMP:** 2019-10-02 [ ] **NA**

3. Pertinent Signs and Symptoms on Admission (tick applicable box/es):

[/] Altered mental sensorium	[ ] Diarrhea	[ ] Hematemesis	[ ] Palpitations
[/] Abdominal cramp/pain	[ ] Dizziness	[ ] Hematuria	[ ] Seizures
[/] Anorexia	[ ] Dysphagia	[ ] Hemoptysis	[ ] Skin rashes
[/] Bleeding gums	[ ] Dyspnea	[ ] Irritability	[ ] Stool, bloody/black tarry/mucoid
[/] Body weakness	[ ] Dysuria	[ ] Jaundice	[ ] Sweating
[/] Blurry of vision	[ ] Epistaxis	[ ] Lower extremity edema	[ ] Urgency
[/] Chest pain/discomfort	[ ] Fever	[ ] Myalgia	[ ] Vomiting
[ ] Constipation	[ ] Frequency of urination	[ ] Orthopnea	[ ] Weight loss
[ ] Cough	[ ] Headache	[/] Pain, Fdgdxdd (site)	[/] Others LABOR PAINS

4. Referred from another health care institution (HCI): [ ] No [/] Yes, Specify Reason zjjsjzz

Name of Originating HCI ssjjsz

5. Physical Examination on Admission (Pertinent Findings per System)

General Survey [ ] Awake and alert [/] Altered sensorium: dsdfsdfs

Vital Signs: BP: _____ HR: /min. RR: /min. Temp: /min.

HEENT:

[ ] Essentially normal	[ ] Abnormal pupillary reaction	[ ] Cervical lymphadenopathy	[/] Dry mucous membrane
[ ] Icteric sclerae	[ ] Pale conjunctivae	[ ] Sunken eyeballs	[ ] Sunken fontanelle

Others: _____

5. Physical Examination continued (Pertinent Findings per System)

CHEST/LUNGS:
- [ ] Essentially normal
- [ ] Asymmetrical chest expansion
- [ ] Decreased breath sounds
- [ ] Wheezes
- [ ] Lump/s over breast(s)
- [/] Rales/crackles/rhonchi
- [ ] Intercostal rib/clavicular retraction

Others: jlkjkjkk

CVS:
- [/] Essentially normal
- [ ] Displaced apex beat
- [ ] Heaves and/or thrills
- [ ] Pericardial bulge
- [ ] Irregular rhythm
- [ ] Muffled heart sounds
- [ ] Murmur

Others: _____

ABDOMEN:
- [ ] Essentially normal
- [ ] Abdominal rigidity
- [ ] Abdomen tenderness
- [ ] Hyperactive bowel sounds
- [ ] Palpable mass(es)
- [ ] Tympanitic/dull abdomen
- [/] Uterine contraction

Others: _____

GU (IE):
- [ ] Essentially normal
- [ ] Blood stained in exam finger
- [ ] Cervical dilatation
- [/] Presence of abnormal discharge

Others: _____

SKIN/EXTREMITIES:
- [ ] Essentially normal
- [/] Clubbing
- [/] Cold clammy skin
- [ ] Cyanosis/mottled skin
- [ ] Edema/swelling
- [ ] Decreased mobility
- [/] Pale nailbeds
- [ ] Poor skin turgor
- [ ] Rashes/petechiae
- [/] Weak pulses

Others: _____

NEURO-EXAM:
- [ ] Essentially normal
- [ ] Abnormal gait
- [ ] Abnormal position sense
- [/] Abnormal/decreased sensation
- [ ] Abnormal reflex(es)
- [ ] Poor/altered memory
- [/] Poor muscle tone/strength
- [/] Poor coordination

Others: _____

IV. COURSE IN THE WARD (Attach photocopy of laboratory/imaging results)

☐ Check box if there is/are additional sheet(s).

DATE	DOCTOR'S ORDER/ACTION

VI. OUTCOME OF TREATMENT

- [ ] IMPROVED
- [ ] HAMA
- [ ] EXPIRED
- [/] ABSCONDED
- [ ] TRANSFERRED

Specify Reason: _____

VII - CERTIFICATION OF HEALTH CARE PROFESSIONAL

Certification of Attending Health Care Professional:

I certify that the above information given in this form, including all attachments, are true and correct.

_____

Signature over Printed Name of Attending Health Care Professional

11 (month) - 19 (day) - 2019 (year)

Date Signed