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
FAMA	FAJAD	ANTOR

2. PIN

3. Age
64 year(s) 11 month(s)

4. Sex
[/] Male [ ] Female

5. Chief Complaint
- dfdfdfsdf

6. Admitting Diagnosis
dfsdfs

7. Discharge Diagnosis
cfgvv

8.a. 1st Case Rate Code

8.b. 2nd Case Rate Code

9.a. Date Admitted: 11 (month) – 20 (day) – 2019 (year)

9.b. Time Admitted 08 (hour) : 10 (min) [ ] AM [/] PM

10.a. Date Discharged: 00 (month) – 00 (day) – 0000 (year)

10.b. Time Discharged 00 (hour) : 00 (min) [ ] AM [ ] PM

III - REASON FOR ADMISSION

1. History of Present Illness:

asasasasa

2.a. Pertinent Past Medical History:

Past Medical History: Cerebrovascular Disease-asd. Diabetes Mellitus-Minor.
Surgery: Surgi (2018-12-04), A (2019-12-03), asd (2018-12-03).
Family History: Cancer-asdad.
Asthma
-asd.
Social History: Non-smoker. Non-alcoholic drinker. No history of drug use
Immunization: Child Immunization, None. Adult Immunization, None.

2.b. OB/GYN History

G N/A **P** N/A **(** ____ **-** ____ **-** ____ **-** ____ **) LMP:** N/A [/] **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, sample other pains (site)	[ ] Others _____

4. Referred from another health care institution (HCI): [ ] No [/] Yes, Specify Reason dfsd dfsdsd dfd dfdfdfd sdfsdfsd dfsd dfsdsd dfd dfdfdfd

Name of Originating HCI dfsd dfsdsd dfd dfdfdfd sdfsdfsd dfsd dfsdsd dfd dfdfdfd

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

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

Vital Signs: BP: 53/23 mmHg HR: 22 /min. RR: 12 /min. Temp: 88 /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: _____

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

12 - 03 - 2019
month day year

Date Signed