**ADMISSION AND DISCHARGE RECORD**

HOSPITAL NO:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Patient’s Name: (Last) (Given) (Middle) Ward Services  Pay PHIC Charity | | | | | | | |
| Permanent Address: Tel. No. Sex Male Civil Status S D Separated  Female M W Ch | | | | | | | |
| Birthdate: | Age: | | Birthplace: | Nationality: | | Religion: | Occupation: |
| Employer Type of Business: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| Admission: Discharge: Admitting Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Total No. of Days  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_  Time: \_\_\_\_\_\_\_\_\_AM/PM Time: \_\_\_\_\_\_\_\_AM/PM Admitted by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date Transferred:  Time\_\_\_\_\_\_\_\_\_\_AM/PM | | | | | | | |
| Type of Admission: New Old Former OPD Referred by: | | | | | | | |
| Medical Service Classification A B C D  Signature of MSW \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| Pts. Allergic to: | | Hospitalization Plan  Company/Industrial Name: | | | Health Insurance Plan | | Medicare:  SSS GSIS |
| Informant: Address: Relation to Patient: | | | | | | | |
| **Admitting Diagnosis: ICD Code No.** | | | | | | | |
| Principal Diagnosis: | | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Other Diagnosis: | |  | | | | | |
| Principal Procedures: | | |  | | | | |
| Minor Operation/Procedures: | | | | |  | | |
| Accidental/Injuries/Poisoning: | | | | |  | | |
| Nature of Occurrences: | | | |  | | | |
| Disposition: |  | | | | | Attending Physician: |  |

Discharge Recovered Died +46 - 46 hours

Transferred Unimproved Autopsy

DAMA Improved No Autopsy

Absconded

\_\_\_\_\_\_\_

NAME & SIGNATURE OF MD Signature Over Printed Name