PhilHealth
Your Partner in Health

CF3

(Claim Form)
revised November 2013

PART I - PATIENT'S CLINICAL RECORD

1. PhilHealth Accreditation No. (PAN) - Institutional Health Care Provider: |__|__|__|__|__|__|__|__|__|__|__|__|

2. Name of Patient

Last Name, First Name, Middle Name (example: Dela Cruz, Juan Jr., Sipag)

3. Chief Complaint / Reason for Admission:

4. Date Admitted: |__|__| – |__|__| – |__|__|__|__| (Month / Day / Year) Time Admitted: |__|__| AM |__|__| PM (hh-mm)

5. Date Discharged: |__|__| – |__|__| – |__|__|__|__| (Month / Day / Year) Time Discharged: |__|__| AM |__|__| PM (hh-mm)

6. Brief History of Present Illness / OB History:

7. Physical Examination (Pertinent Findings per System)

General Survey:

Vital Signs : BP : _____ CR: _____ RR: _____ Temperature: _____

HEENT :

Chest/Lungs :

CVS :

Abdomen :

GU (IE) :

Skin/Extremities :

Neuro Examination :

8. Course in the Wards (attach additional sheets if necessary):

9. Pertinent Laboratory and Diagnostic Findings: (CBC, Urinalysis, Fecalysis, X-ray, Biopsy, etc.)

10. Disposition on Discharge: ☐ Improved ☐ Transferred ☐ HAMA ☐ Absconded ☐ Expired

PART II- MATERNITY CARE PACKAGE

PRENATAL CONSULTATION

1. Initial Prenatal Consultation ___ – ___ – ____ (Month – Day – Year)

2. Clinical History and Physical Examination

a. Vital signs are normal ☐

c. Menstrual History LMP ___ – ___ – ____ (Month – Day – Year) Age of Menarche _____

b. Ascertain the present Pregnancy is low-Risk ☐

d. Obstetric History G _____ P _____ (___,___,___,___) (T, P, A, L)

3. Obstetric risk factors

a. Multiple pregnancy	☐	d. Placenta previa	☐	g. History of pre-eclampsia	☐
b. Ovarian cyst	☐	e. History of 3 miscarriages	☐	h. History of eclampsia	☐
c. Myoma uteri	☐	f. History of stillbirth	☐	i. Premature contraction	☐

4. Medical/Surgical risk factors

a. Hypertension	☐	d. Thyroid Disorder	☐	g. Epilepsy	☐	j. History of previous cesarian section	☐
b. Heart Disease	☐	e. Obesity	☐	h. Renal disease	☐	k. History of uterine myomectomy	☐
c. Diabetes	☐	f. Moderate to severe asthma	☐	i. Bleeding disorders	☐		

5. Admitting Diagnosis _____

6. Delivery Plan

a. Orientation to MCP/Availment of Benefits ☐ yes ☐ no

b. Expected date of delivery ___ – ___ – ____ (Month – Day – Year)

7. Follow-up Prenatal Consultation

	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th
a. Prenatal Consultation No.											
b. Date of visit (mm/ dd/ yy)											
c. AOG in weeks											
d. Weight & Vital signs:											
d.1. Weight											
d.2. Cardiac Rate											
d.3. Respiratory Rate											
d.4 Blood Pressure											
d.5. Temperature											

DELIVERY OUTCOME

8. Date and Time of Delivery Date ___ – ___ – ____ (Month – Day – Year) Time ___ AM ___ PM (hh-mm, hh-mm)

9. Maternal Outcome: _____ (Obstetric Index) Pregnancy Uterine, _____ (AOG by LMP) _____ (Manner of Delivery) _____ (Presentation)

10. Birth Outcome: _____ (Fetal Outcome) _____ (Sex) _____ (Birth Weight (grm)) _____ (APGAR Score)

11. Scheduled Postpartum follow-up consultation 1 week after delivery ___ – ___ – ____ (Month – Day – Year)

12. Date and Time of Discharge Date ___ – ___ – ____ (Month – Day – Year) Time ___ AM ___ PM (hh-mm, hh-mm)

POSTPARTUM CARE

	done	Remarks
13. Perineal wound care	☐	
14. Signs of Maternal Postpartum Complications	☐	
15. Counselling and Education		
a. Breastfeeding and Nutrition	☐	
b. Family Planning	☐	
16. Provided family planning service to patient (as requested by patient)	☐	
17. Referred to partner physician for Voluntary Surgical Sterilization (as requested by pt.)	☐	
18. Schedule the next postpartum follow-up	☐	

19. Certification of Attending Physician/Midwife:

I certify that the above information given in this form are true and correct.

_____
Signature Over Printed Name of Attending Physician/Midwife

___ ___ ____
Date Signed (Month / Day / Year)