



PhilHealth Konsulta Registration Form (PKRF)

Instruct ions

1. All information should be written in UPPERCASE/CAPITAL LETTER.
3. If the beneficiary is dependent use the dependent PIN.
4. If the beneficiary is below 21 years old, the signatory should be parent/guardian.



TO BE FILLED- OUT BY THE BENEFICIARY

MEMBER DEPENDENT

PIN: _____ DATE: _____

FULL NAME: _____ LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____

ADDRESS: _____ BARANGAY/TOWN _____ MUNICIPALITY/CITY _____ PROVINCE _____

DATE OF BIRTH (MM/DD/YYYY): _____ CONTACT NO.: _____

REGISTER TO A KONSULTA PACKAGE PROVIDER (KPP) (please use additional form if necessary)
 REGISTER ALL MY DECLARED MINOR DEPENDENTS

FULL NAME: _____ LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____

1ST CHOICE KPP: _____ MUNICIPAL HEALTH OFFICE BURAEN LEYTE

ADDRESS: _____ LGU COMPOUND, DISTRICT 7, BURAEN LEYTE

BARANGAY/TOWN _____ MUNICIPALITY/CITY _____ PROVINCE _____

2ND CHOICE KPP: _____

ADDRESS: _____ BARANGAY/TOWN _____ MUNICIPALITY/CITY _____ PROVINCE _____

TRANSFER

PREVIOUS KPP: _____

1ST CHOICE KPP: _____ MUNICIPAL HEALTH OFFICE BURAEN LEYTE

ADDRESS: _____ LGU COMPOUND, DISTRICT 7, BURAEN LEYTE

BARANGAY/TOWN _____ MUNICIPALITY/CITY _____ PROVINCE _____

2ND CHOICE KPP: _____

ADDRESS: _____ BARANGAY/TOWN _____ MUNICIPALITY/CITY _____ PROVINCE _____

I hereby certify that I did not avail of FPE in other KPP. Moreover, I grant free and voluntary consent to the collection, transmission and processing of my personal data and health records to Philhealth for the purpose of paying and monitoring the provider for the Konsulta benefit in accordance with the Republic Act No. 10173, otherwise known as the "Data Privacy Act of 2012".

(Signature over Printed Name)

TO BE FILLED- OUT BY PHILHEALTH KONSULTA PERSONNEL

PHILHEALTH KONSULTA REGISTRATION CONFIRMATION SLIP

REGISTRATION NO.: _____ DATE REGISTERED: _____

FULL NAME (LAST NAME, FIRST NAME, MIDDLE NAME): _____

PIN: _____ DATE OF BIRTH: _____

KPP: _____ MUNICIPAL HEALTH OFFICE BURAEN LEYTE

ADDRESS: _____ LGU COMPOUND, DISTRICT 7, BURAEN LEYTE

(Signature over Printed Name of Authorized Personnel)

PHOTO CONSENT FORM



I, _____ with address _____ grant permission and give my consent to **MUNICIPAL HEALTH OFFICE BURAEN LEYTE** for the use of my photo or picture as one of the requirements in the availment of **Konsulta Benefit/Yakap**.

By Signing below, I hereby authorize my Konsulta Facility to save my photo for post-audit monitoring purposes of PhilHealth.

Name of Konsulta Beneficiary

Signature

Date

HEALTH SCREENING FORM/ FIRST PATIENT ENCOUNTER

INDIVIDUAL HEALTH PROFILE

*Health Screening Date (mm/dd/yyyy) _____

Barangay: _____

I. Client Details:

Last Name: _____ First Name: _____ Middle Name: _____

Extension Name: _____ Age: _____ Date of Birth (mm/dd/yyyy) _____

Sex/ Gender: _____ Client Type: _____

II. REVIEW OF SYSTEMS

1. Chief complaint (please describe) _____

2. Do you experience any of the following: fever, cough, colds, or headache?
 Yes or No If yes, please explain: _____

3. Do you experience any of the following: unexplained change in weight, loss of appetite, Change in bowel movement, or abdominal pain?
 Yes or No If yes, please explain: _____

4. Do you experience any of the following: chest pain or difficulty in breathing?
 Yes or No If yes, please explain: _____

5. Do you experience any of the following frequent urination, frequent eating, and frequent intake of fluids?
 Yes or No If yes, please explain: _____

6. For male and female, do you experience any of the following: pain or discomfort on urine or frequency in urination?
 Yes or No If yes, please explain: _____

7. For FEMALE ONLY, a. Number of Pregnancy: _____

b. Last menstrual period (mm/dd/yyyy) _____

c. First menstrual period (mm/dd/yyyy) _____

8. Do you experience any of the following, muscle spasm, tremors, weakness; muscle/joint pain, stiffness, limitation of movement?
 Yes or No If yes, please explain: _____

IV. PAST MEDICAL HISTORY

| | | | | |
|---------------------------------|--|---------------------------------------|------------------------------------|---------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Allergies | <input type="checkbox"/> Others |
|---------------------------------|--|---------------------------------------|------------------------------------|---------------------------------|

| | | | | |
|-----------------------------------|---------------------------------------|---|----------------------|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> COPD/emphysema /bronchitis | please Specify _____ | |
|-----------------------------------|---------------------------------------|---|----------------------|--|

| | | | | |
|---------------------------------|--|-------------------------------|--|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Brochial asthma | <input type="checkbox"/> None | | |
|---------------------------------|--|-------------------------------|--|--|

V. PERTINENT PHYSICAL EXAMINATION FINDINGS

Blood Pressure _____ / _____ mmHg Height: _____ (cm) _____ (h)

Heart Rate: _____ / min Weight: _____ (kg) _____ (lb.)

Respiratory Rate: _____ / min BMI: _____

Visual Rate; (R) _____ / (L) _____ Temperature: _____

Pediatric Client aged 0-24 months

Length: _____ (cm) Head Circumference: _____ (cm)

Body Circumference Waist _____ (cm) Hip _____ (cm) Limbs _____ (cm)

Middle and Upper Arm _____ (cm) Skinfold Thickness _____ (cm)

Blood Type (as available)

| | | | | | |
|-----------------------------|------------------------------|-----------------------------|------------------------------|-----------------------------|-----------------------------|
| <input type="checkbox"/> A+ | <input type="checkbox"/> AB+ | <input type="checkbox"/> O+ | <input type="checkbox"/> O-A | <input type="checkbox"/> B- | <input type="checkbox"/> O- |
|-----------------------------|------------------------------|-----------------------------|------------------------------|-----------------------------|-----------------------------|

General Survey Awake and alert Altered Sensorium

~~~~~If the answer is YES to Question 1-8, the beneficiary needs to consult a doctor.~~~~~

#### III. PERSONAL/ SOCIAL HISTORY

1. Do you smoke cigar, cigarette, e-cigarette, vape, or other similar products?  Yes  No Number of years: \_\_\_\_\_

2. Do you drink alcohol or alcohol-containing beverages?  Yes  No Number of years: \_\_\_\_\_