

A. PARTICULARS

1.Name Of Health Facility:St.Joseph hospital

2.Address:DAR ES SALAAM-TANZANIA-11007

3.Consultation Fees:

4.Department:Out

5.Date Of Attendance:2019-11-16

6.Patient File No:2019/11/MH62547

7.Name Of Patient:HALIMAJUMA

8.DOB:1995-11-07

9.Sex M/F:F

10.Vote:

11.Patient Physical Address:DAR ES SALAAM-TANZANIA-11007

12.Card No:

13.Occupation:NONE

14.Preliminary Diagnosis (Code):

15.Final Diagnosis(Code):

B. COSTS OF SERVICES

Description	Item Code	Qty	Unit Price	Amount
Consultation				
SUB TOTAL				0
Medicine				
Ceftriaxone(Rocephine)	300472	5	13300	66500
Praziquantel/Biltricide/	11091	3	500	1500
Ceftriaxone(Rocephine)	300472	5	13300	66500
Praziquantel/Biltricide/	11091	3	500	1500
SUB TOTAL				136000
GRAND TOTAL				136000

C.Name of attending Clinician:

Qualification:

Reg.No:

Signature:

Mob No:

D.Patient Certification:

I certify that I received the above named services. Name:HALIMAJUMA Mob No:0754272716 Signature:

E.Descriptionof Out/In-patient Management/Any other additional information:

F.Claimant Certification:

I certify that I provide the above names services. Name: Signature:

Patient should sign the form after completion of service
Before referring patient to other facility, referring facility should be satisfied for the missing item and its alternative within the facility.
Any falsified information may subject you to prosecutionin accordancewith NHIF Act No.8 of 1999.