

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 ADMINISTRATIVE LIABILITIES.
I. HEALTH CARE INSTITUTION (HCI) INFORMATION

1. Name of HCI		2. Accreditation Number		
3. Address of HCI				
Bldg No. and Name/Lot/Block	Street/Subdivision/Village	Barangay/City/Municipality	Province	Zip Code

II. PATIENT'S DATA

1. Name of Patient			2. PIN	
Last Name	First Name	Middle Name	3. Age	
5. Chief Complaint			4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
6. Admitting Diagnosis		7. Discharge Diagnosis		8. a. 1st Case Rate Code
				8. b. 2nd Case Rate Code
9. a. Date Admitted: _____ - _____ - _____ <small>month day year</small>		9. b. Time Admitted: _____ : _____ <input type="checkbox"/> AM <input type="checkbox"/> PM <small>hour min</small>		
10. a. Date Discharged: _____ - _____ - _____ <small>month day year</small>		10. b. Time Discharged: _____ : _____ <input type="checkbox"/> AM <input type="checkbox"/> PM <small>hour min</small>		

III. REASON FOR ADMISSION

1. History of Present Illness:

2.a. Pertinent Past Medical History:

2.b. OB/GYN History
 G _____ P _____ (_____ - _____ - _____) LMP: _____ NA

3. Pertinent Signs and Symptoms on Admission (tick applicable box/es):

<input type="checkbox"/> Altered mental sensorium	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Hematemesis	<input type="checkbox"/> Palpitations
<input type="checkbox"/> Abdominal cramp/pain	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Hematuria	<input type="checkbox"/> Seizures
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Dysphagia	<input type="checkbox"/> Hemoptysis	<input type="checkbox"/> Skin rashes
<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Dyspnea	<input type="checkbox"/> Irritability	<input type="checkbox"/> Stool, bloody/black tarry/mucoid
<input type="checkbox"/> Body weakness	<input type="checkbox"/> Dysuria	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Sweating
<input type="checkbox"/> Blurring of vision	<input type="checkbox"/> Epistaxis	<input type="checkbox"/> Lower extremity edema	<input type="checkbox"/> Urgency
<input type="checkbox"/> Chest pain/discomfort	<input type="checkbox"/> Fever	<input type="checkbox"/> Myalgia	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Constipation	<input type="checkbox"/> Frequency of urination	<input type="checkbox"/> Orthopnea	<input type="checkbox"/> Weight loss
<input type="checkbox"/> Cough	<input type="checkbox"/> Headache	<input type="checkbox"/> Pain, _____(site)	<input type="checkbox"/> Others _____

4. Referred from another health care institution (HCI): No Yes, Specify Reason _____
 Name of Originating HCI _____

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

General Survey Awake and alert Altered sensorium: _____

Vital Signs: BP: _____ HR: _____ RR: _____ Temp: _____

HEENT: Essentially normal Abnormal pupillary reaction Cervical lymphadenopathy Dry mucous membrane
 Icteric sclerae Pale conjunctivae Sunken eyeballs Sunken fontanelle

Others: _____

