ANNEX 9. REFERRAL FORM

Referral Form

Referring Health Care Institution

Date of Referral: ____________________________ Time of Referral: ___________________________

Name of Health Care Institution (HCI): ____

PhilHealth Accreditation No. of HCI: ____

Address of HCI: ____

Name of Attending/Referring Physician: ____

Signature of Attending/Referring Physician: ____

Patient Information

Name of Patient: __________________________________

Date of Birth: _____________________________________ Age: __________

Diagnosis/es: ____ ICD 10 Code: _____________________

Reasons for referral/transfer: ___________ ____

Referral Health Care Institution

Date of Receipt: _____________________________ Time of Receipt: ___________________________

Name of Health Care Institution (HCI): ____

PhilHealth Accreditation No. of HCI: ____

Address of HCI: ____

Name of Receiving Physician: ____

Signature of Receiving Physician: ____

Name of Nurse on Duty: ____

Signature of Nurse on Duty: ____