



# 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)

4. Date Admitted:  -  -  Time Admitted: AM PM  
Month Day Year hh-mm hh-mm

5. Date Discharged:  -  -  Time Discharged: AM PM  
Month Day Year hh-mm hh-mm

3. Chief Complaint / Reason for Admission:

6. Brief History of Present Illness / OB History:

7. Physical Examination ( Pertinent Findings per System )

General Survey:

Vital Signs : BP : \_\_\_\_\_ CR: \_\_\_\_\_ RR: \_\_\_\_\_ Temperature: \_\_\_\_\_ Abdomen :

HEENT : GU ( IE ) :

Chest/Lungs : Skin/Extremities :

CVS : Neuro Examination :

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

9. Pertinent Laboratory and Diagnostic Findings: ( CBC, Urinalysis, Fecalalysis, 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
- b. Ascertain the present Pregnancy is low-Risk
- c. Menstrual History LMP  -  -  Age of Menarche \_\_\_\_\_  
Month Day Year
- d. Obstetric History G \_\_\_\_\_ P \_\_\_\_\_ (    ,    ,    ,    )  
T P A L

3. Obstetric risk factors

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

4. Medical/Surgical risk factors

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

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

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

**DELIVERY OUTCOME**

8. Date and Time of Delivery Date  -  -  Time  AM  PM  
Month Day Year hh-mm hh-mm

9. Maternal Outcome: \_\_\_\_\_ Pregnancy Uterine, \_\_\_\_\_  
Obstetric Index AOG by LMP Manner of Delivery Presentation

10. Birth Outcome: \_\_\_\_\_  
Fetal Outcome Sex Birth Weight (gm) APGAR Score

11. Scheduled Postpartum follow-up consultation 1 week after delivery  -  -   
Month Day Year

12. Date and Time of Discharge Date  -  -  Time  AM  PM  
Month Day Year hh-mm hh-mm

**POSTPARTUM CARE**

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

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)