Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8441-7442 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH FACILITY (HF)		DATE OF ASSESSMENT (mm/dd/yyyy)
ADDRESS OF HF		AGE: _____
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	**(Answer only if the patient is a dependent; otherwise, write, "same as above")** 1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

MENTAL HEALTH PASSPORT

A. Follow – up Visits

Follow-up visits	Date of Visit (mm/dd/yyyy)	Date of Next Visit (mm/dd/yyyy)	Patient/ Parent/ Guardian's Signature	Attending Physician's signature	MH Coordinator's Signature
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					

B. Medications

Name of Medicine	Dosage	Preparation	Date Given (mm/dd/yyyy)	Patient/ Parent/ Guardian's Signature	Attending Physician's signature