Annex K: OTC/ITC SAM Referral Form

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Referral / Transfer Form (SAM) - Copy for Receiving Facility (OTC/ITC)

Name: ______________________ Sex: __ Date of Birth: __________ Age: ______ months/years

Admission information: MUAC _______________ Date of Referral: ______________________

Name mother/caregiver (for child): ____

Registration Number (mother/caregiver): ________________ Contact Number: ______________

Municipality: ______________________________ Barangay: ______________House No.______

To be completed by referral focal point (ie. RHU staff - midwife/nurse/doctor)

Referred to/Transfer to: OTC / ITC Date of referral / transfer: ______________________

Weight __________ Height__________ WH Z score (if used) ____________Edema (circle) + ++ +++

Refer/Transfer from: __________________________________ (Name of Brgy/Health Center/OTC/Hospital)

Refer/Transfer to: ______________________________________ (Name of Brgy/Health Center/ OTC /Hospital)

Reason for transfer (circle): Anorexia (no appetite) Complications Edema No weight gain Other:__________

Referred/Transferred by (name of Health Worker): ___________________ Contact Number: ________________

Received by (name of Health Worker):__________________________ Contact Number: ___________________

Referral / Transfer Form (SAM) - Copy for Referring Facility (OTC/ITC)

Name: ____________________ Sex: __ Date of Birth: __________ Age: _____ months/years

Admission information: MUAC ______________ Date of Referral: ____________________

Name mother/caregiver (for child): ____

Registration Number (mother/caregiver): _______________ Contact Number: _____________

Municipality: ____________________________ Barangay: _____________House No._____

To be completed by referral focal point (ie. RHU staff - midwife/nurse/doctor)

Referred to/Transfer to: OTC / ITC Date of referral / transfer: _______________________

Weight _________ Height_________ WH Z score (if used) ___________Edema (circle) + ++ +++

Refer/Transfer from: _________________________________ (Name of Brgy/Health Center/OTC/Hospital)

Refer/Transfer to: ___________________________________ (Name of Brgy/Health Center/ OTC /Hospital)

Reason for transfer (circle): Anorexia (no appetite) Complications Edema No weight gain Other:_________

Referred/Transferred by (name of Health Worker): __________________ Contact Number: _______________

Received by (name of Health Worker):________________________ Contact Number: __________________