*Republic of the Philippines*
**PHILIPPINE HEALTH INSURANCE CORPORATION**
Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 Trunkline (02) 441-7444
www.philhealth.gov.ph

**Case No. _____**

**Annex "F –Preterm and small baby"**

| |
|---|
| HEALTH CARE INSTITUTION (HCI) WHERE PATIENT IS REFERRED TO |
| ADDRESS OF HCI |
| PATIENT (Last name, First name, Middle name, Suffix) |
| PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐ - ☐ |
| MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix) |
| PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐ - ☐ |

## COORDINATED REFERRAL & TRANSFER FORM

☐ Antepartum ☐ Intrapartum ☐ Postpartum

| | |
|---|---|
| Date of Transfer (mm/dd/yyyy) | Method of transport |
| Transfer from: (Birthing home) | Contact number of birthing home |
| Referred by: (Physician/Midwife) | Contact number of physician/midwife |
| Obstetrical Care Provider: (Physician/Midwife) | Contact number of physician/midwife |
| Name of Accepting Physician | Contact number of accepting physician |
| Date of Referral (mm/dd/yyyy) | Time: _____:_____ AM/PM |

| | |
|---|---|
| **Reason for Transfer**<br>☐Retro-transfer ☐Acute transfer | ☐ Maternal (describe)<br>☐ Fetal (describe)<br>☐ Small baby for continuing care |
| **Allergies** | ☐ No known allergies<br>☐ Specify (drug, food, tape, dyes, latex, other) _____<br>and reactions _____ |
| **Obstetric history** | ☐ Copy of chart with patient and additional information, if indicated |
| Gravida: _____ Para: _____ LMP: _____ EDB/C: _____ Gestation (weeks + days) _____ | |
| Past C-Section or Uterine Surgery: _____ Incision Type: _____ | |
| **Labour & Birth** | Onset of Labour: _____ Membranes Ruptured: ☐ Yes ☐ No<br>Time: Colour: _____ |
| Cervical Exam: _____ /_____ /_____ Fetal Position: A: _____ B: _____ C: _____ | |
| Placenta (multiples): ☐ DI/DI ☐MONO/DI ☐MONO/MONO ☐Other:_____ | |
| Maternal VS:BP _____ / _____ Pulse: _____ Resp: _____ Temp: _____ | |
| Partograph attached? ☐ Yes ☐ No; If Yes, correctly filled out? ☐ Yes ☐ No | |
| Comments: | |

| Medications | Regular medications: | | |
|---|---|---|---|
| Antibiotics: | Date: | Time: | Others: |
| Steroids: | Date: | Time: | |
| $MgSO_4$ ☐Seizure prophylaxis ☐Neuroprotection | Date: | Time: | |
| Medical/Surgical History | ☐ See chart | | |
| Relevant medical/surgical history | | | |
| Social Issues | ☐ See chart | | |
| Intransit | ☐ See transport record IV:___ TBA on arrival ___ mL Rate ___ mL/hr | | |

| Time | FHR | Pulse | Resp | BP | Contractions | | | Medications | Comments |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | Frequency | Duration | Intensity | Dose/Route | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
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| | | | | | | | | | |

| Transfer Information | Departure Time: _____ Time of Arrival at Receiving HCI: _____ |
|---|---|

☐ See transport record Accompanied by: _____ Relationship: _____ Attendant during transport _____

Signature /Status: _____ Print Name: _____

| Certified correct by: | Conforme by: |
|---|---|
| (Printed name and signature)<br>Attending Physician | (Printed name and signature)<br>Patient/Parent/Guardian |
| PhilHealth Accreditation No. ☐☐☐☐–☐☐☐☐☐☐☐–☐ | Date signed (mm/dd/yyyy) |
| Date signed (mm/dd/yyyy) | |