Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center: (02) 8441-7442 Trunkline: (02) 8441-7444
www.philhealth.gov.ph

Registry No. ______________

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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	☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

COORDINATED REFERRAL & TRANSFER FORM

☐ Antepartum ☐ Intrapartum ☐ Postpartum

Date of Referral (mm/dd/yyyy):	Time of Referral:
Name of Referring Facility:	*Contact number of referring facility:*
Referred by: (Physician/Midwife)	Contact number of physician/midwife:
Name of Referral Facility:	*Contact number of referral facility:*
Name of Accepting Physician:	Contact number of accepting physician:
Reason for Transfer:	
Mode of Transfer:	
Date of Transfer (mm/dd/yyyy):______________ Time of Departure:: __:__ AM/PM	Date of Arrival (mm/dd/yyyy): ______________ Time of Arrival in Referral Facility: __:__ AM/PM
Name of Patient's Guardian: ________________________ **Relationship to patient:**_____________________________	

Chief complaint	
Obstetric History	Gravida___ Para___ (T __ P __ A __ L __) LMP: _______ EDC: ______ Age of Gestation: _____
Labor	Onset of Labor: ______ Rupture of Membranes: Yes __ No__ Time: _____ Color: _____
	Maternal Vital Signs (see table below) Pertinent physical exam findings: Fundic Height ____ Contractions: Frequency ____ Duration ____ Intensity___
	Partograph attached? ___Yes __ No If *no partograph attached*, cervical dilatation (if with no contraindications) prior to transfer : _____
Medications given:	(see table below)

Maternal Vital Signs

	Initial vital signs	Prior to transfer
Blood Pressure		
Pulse Rate		
Resp Rate		
Temperature		
Fetal Heart Tones		

Medications given:

	Dose	Date	Time given
Antibiotics:			
Antenatal steroids:			
Magnesium sulfate			
IV fluids			
Others			

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In Transit

Time	Blood pressure	Pulse Rate	Respiratory Rate	Fetal Heart tones	Contractions Frequency / Duration / Intensity	Medications	Comments

Name and Signature of Accompanying Healthcare Professional	Name and Signature of Receiving Healthcare Professional

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Parent/Guardian
PhilHealth Accreditation No. ____ – ________ – _	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	