PhilHealth
Your Partner in Health

CF3

(Claim Form)
revised February 2010

IMPORTANT REMINDERS:

THIS FORM SHOULD BE FILED TOGETHER WITH PHILHEALTH CLAIM FORMS 1 AND 2 WITHIN 60 CALENDAR DAYS FROM DATE OF DISCHARGE.
FOR LEVEL 1 FACILITY, THIS FORM SHALL BE REQUIRED FOR ALL BENEFIT CLAIMS.
FOR LEVELS 2, 3 AND 4 FACILITIES, THIS FORM IS REQUIRED IN CASES OF: 1) EMERGENCY/TRANSFERRED 2) LESS THAN 24 HOURS ADMISSION 3) CASE TYPE 'D' DIAGNOSIS.
THIS FORM SHALL BE REQUIRED FOR ALL CLAIMS ON MATERNITY CARE PACKAGE.

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)

3. Chief Complaint / Reason for Admission:

4. Date Admitted: |_|_| – |_|_| – |_|_|_|_| (Month – Day – Year) Time Admitted: |_|_| AM |_|_| PM (hh-mm)

5. Date Discharged: |_|_| – |_|_| – |_|_|_|_| (Month – Day – Year) Time Discharged: |_|_| AM |_|_| PM (hh-mm)

6. Brief History of Present Illness / OB History:

7. Physical Examination (Pertinent Findings per System)

General Survey:

Vital Signs : BP : _____ CR: _____ RR: _____ Temperature: _____

HEENT :

Chest/Lungs :

CVS :

Abdomen :

GU (IE) :

Skin/Extremities :

Neuro Examination :

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

9. Pertinent Laboratory and Diagnostic Findings: (CBC, Urinalysis, Fecalysis, 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 ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year) Age of Menarche _____

d. Obstetric History G _____ P _____ (____ / ____ / ____ / ____) (T P A L)

3. Obstetric risk factors

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

4. Medical/Surgical risk factors

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

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

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

DELIVERY OUTCOME

8. Date and Time of Delivery Date ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year) Time ☐☐ AM ☐☐ PM (hh-mm hh-mm)

9. Maternal Outcome: _____ (Obstetric Index) Pregnancy Uterine, _____ (AOG by LMP) _____ (Manner of Delivery) _____ (Presentation)

10. Birth Outcome: _____ (Fetal Outcome) _____ (Sex) _____ (Birth Weight (grm)) _____ (APGAR Score)

11. Scheduled Postpartum follow-up consultation 1 week after delivery ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)

12. Date and Time of Discharge Date ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year) Time ☐☐ AM ☐☐ PM (hh-mm hh-mm)

POSTPARTUM CARE

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

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)