PhilHealth
Your Partner in Health

CF4

(Claim Form 4)
February 2020

Series # _____

IMPORTANT REMINDERS:
PLEASE FILL UP APPROPRIATE FIELDS. WRITE IN CAPITAL **LETTERS** AND **CHECK** THE APPROPRIATE
This form together with other supporting documents should be filed within **sixty(60) calendar days** from date of discharge.
All information, fields and tick boxes required in this form are necessary. **Claim forms with incomplete information shall not be processed.**
FALSE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.

I. HEALTHCARE INSTITUTION (HCI) INFORMATION

1. Name of HCI: MEDSYS MEDICAL CENTER
2. Accreditation Number: H93005896
3. Address of HCI: 960 AURORA BLVD. , QUEZON CITY, MANILA, 1109

Bldg no. and name/Lot/Block	Street/Subdivision/Village	Barangay/City/Municipality	Province	Zip Code

II. PATIENT'S DATA

1. Name of Patient:

Last Name	First Name	Extension	Middle Name
KAI LN FORTY	KAI FN FORTY	N/A	KAI MN FORTY

2. PIN: 19-027063334-3
3. Age: 51
4. Sex: ☐ Male ☑ Female
5. Chief Complaint: FOR HEMO
6. Admitting Diagnosis: END STAGE RENAL DISEASE
7. Discharge Diagnosis: HEMODIALYSIS
8.a. 1st Case Rate Code: N/A
8.b. 2nd Case Rate Code: N/A

9.a. Date Admitted: 04 (month) 16 (day) 2025 (year) **9.b. Time-Admitted:** 1 (hour) : 35 (min) ☐ AM ☑ PM

10.a. Date Discharged: 04 (month) 16 (day) 2025 (year) **10.b. Time Discharged:** 1 (hour) : 47 (min) ☐ AM ☑ PM

III. REASON FOR ADMISSION

1. History of Present Illness:
THE PATIENT IS KAI LN FORTY, KAI FN FORTY KAI MN FORTY, FEMALE, 51 YEARS OLD FROM CARLATAN SAN FERNANDO, A DIAGNOSED CASE OF END STAGE RENAL DISEASE AND WAS ADVISED TO HAVE REGULAR _ TIMES A WEEK HEMODIALYSIS HERE AT THE HOSPITAL.

2.a. Pertinent Past Medical History:
HEMODIALYSIS TEST

2.b. OB/GYN History
G__ P__ (__ - __ - __ - __) **LMP:** _____ ☑ **N/A**

3. Pertinent Signs and Symptoms:

☐ Altered mental sensorium	☐ Diarrhea	☐ Hematemesis	☐ Palpitations
☐ Abdominal cramp/pain	☐ Dizziness	☐ Hematuria	☐ Seizures
☐ Anorexia	☐ Dysphagia	☐ Hemoptysis	☐ Skin rashes
☐ Bleeding gums	☐ Dyspnea	☐ Irritability	☐ Stool, bloody/black tarry/mucoid
☐ Body weakness	☐ Dysuria	☑ Jaundice	☐ Sweating
☐ Blurring vision	☐ Epistaxis	☐ Lower extremity edema	☐ Urgency
☐ Chest pain/discomfort	☐ Fever	☐ Myalgia	☐ Vomiting
☐ Constipation	☐ Frequency of urination	☐ Orthopnea	☐ Weight loss
☐ Cough	☐ Headache	☐ Pain, _____(site)	☐ **Others:** N/A

4. Referred from another health care institution (HCI): ☑ No ☐ Yes, Specify Reason N/A
Name of Originating HCI N/A

5.Physical Examination (Pertinent Findings per System)

General Survey: ☑ Awake and alert ☐ Altered sensorium: _____

Height: 162 (cm)
Weight: 50 (kg)

Vital Signs: **BP:** 100/90 **HR:** _____ **RR:** _____ **Temp:** 36

HEENT: ☑ Essentially normal ☐ Abnormal pupillary reaction ☐ Cervical lympadenopathy ☐ Dry mucous membrane
☐ Icteric sclerae ☐ Pale conjunctivae ☐ Sunken eyeballs ☐ Sunken fontanelle
Others: _____