Province of Laguna
City of Santa Rosa
City Health Office II

INTER-HEALTH FACILITY REFERRAL SLIP

Control Number: ____________________

Referred to: ________________ Date: _______________

Health Facility: ______________________

Patient Name: __________________________________ Age: ___________ Occupation: ______________

Address: _______________________________________ Sex: ___________ Civil Status:______________

Philhealth No: __________________________________ Family No.:_______________________________

BRIEF CLINICAL HISTORY AND PHYSICAL EXAMINATION (including present and past history)

WORKING IMPRESSION:

ACTION UNDERTAKEN:

REASON FOR REFERRAL:

REFERRED BY: __________________________________

Printed Name and Signature

CHO2 – FRS – F07