



Province of Laguna
City of Santa Rosa
City Health Office II



ROUTING SLIP FORM

Date: _____

Name: _____ Age: _____
Address _____ Sex: _____
Queuing Number: _____

- | | |
|---|--|
| <input type="checkbox"/> General Consultation | <input type="checkbox"/> Admin Office |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Death Certificate |
| <input type="checkbox"/> TB DOTS | <input type="checkbox"/> Transfer of Cadaver |
| <input type="checkbox"/> ABTC | <input type="checkbox"/> Sanitation |
| <input type="checkbox"/> Family Planning | <input type="checkbox"/> Prenatal/Postpartum |
| <input type="checkbox"/> Laboratory | <input type="checkbox"/> Baby's Immunization |
| <input type="checkbox"/> Medical Officer | <input type="checkbox"/> Birthing Facility |
| <input type="checkbox"/> Pharmacy | <input type="checkbox"/> City Health Officer |

Completed by:

Staff Name and Date

CHO2 - ARS - F10



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