**Republic of the Philippines**

**Department of Health**

**OFFICE OF THE SECRETARY**

**ADMINISTRATIVE ORDER**

**NO. 2012 - \_\_\_\_\_\_\_\_\_\_\_\_**

**SUBJECT:** **National Implementation of the Unified Registry Systems on Chronic Non-Communicable Diseases, Injury Related Cases, Persons with Disabilities, and Violence Against Women and Children**

# RATIONALE

Non-communicable diseases are the top causes of death worldwide, killing more than 36 million people in 2008. Cardiovascular diseases were responsible for 48% of these deaths, cancers 21%, chronic respiratory diseases 12%, and diabetes 3% based on the World Health Organization report on *Non-communicable Diseases Country Profiles 2011part.*  In the Philippines, cardiovascular diseases, cancers, chronic respiratory diseases and diabetes are among the top killers causing more than half of all deaths annually. Hypertension and diseases of the heart are among the ten leading causes of illnesses each year. These lifestyle related non-communicable diseases have common risk factors which are to a large extent related to unhealthy lifestyle particularly tobacco use, unhealthy diet, physical inactivity and alcohol use (National Objectives for Health 2005-2010).

These evident data have pushed international organizations to take actions and drive the entire world to prevent these kinds of diseases, which are long in duration and generally slow in progression. Recognizing the urgency of the situation, the Department of Health (DOH) as the principal health agency in the Philippines, took on the lead in making policies and programs that could lessen these cases. In April 14, 2011, **Administrative Order No. 2011-0003** or the National Policy on Strengthening the Prevention and Control of Chronic Lifestyle Related Non Communicable Disease was issued. The Order states that the Department of Health shall provide leadership in addressing lifestyle related non-communicable diseases and institute measures in ensuring that the programs for prevention are met and implemented. Section XI, Item No. 5 states that the National Epidemiology Center and the Information Management Service shall establish and sustain public health and hospital surveillance systems including registries, for lifestyle-related diseases and other non-communicable diseases.

On the other hand, in the Asia Pacific Region, it is estimated that injuries caused about 2.7 million deaths in 2002, or over 7000 deaths daily, which constituted 52% of worldwide injury deaths. In response to the injury-related problems, the Department of Health has created **Administrative Order No. 2007-0010**, dated March 19, 2007, the National Policy on Violence and Injury Prevention. This established a national policy and strategic framework for injury prevention activities for DOH and other government agencies, local government units, non-government organizations, communities and individuals. Related to injury is violence against women and children which is not merely a health concern and requires a whole range of medical, social, and non-medical interventions and services. ***Administrative Order No. 1-B, s. 1997*** established a Women and Children Protection Unit in All DOH Hospitals. Further, the DOH supports the program on persons with disabilities and has created ***Administrative Order No. 16-A, s. 1999*** which established the Guidelines on the Issuance of Certification of Disability to Persons with Disabilities.

To make available the data on chronic non-communicable diseases, injury, violence and disabilities, the Unified Registry Systems were developed by the DOH. These are the Integrated Chronic Non-Communicable Diseases, Online National Electronic Injury Surveillance System, Philippine Registry for Persons with Disabilities, and Violence Against Women and Children Registry System. This Order mandates all government and private clinics and hospitals to submit reportable cases of chronic non-communicable diseases, injuries, violence, and disabilities to the DOH Information Management Service, and defines the implementing procedures and guidelines related thereto.

1. **DECLARATION OF POLICIES**

This Order complements the following issuances or provisions:

1. ***The 1987 Philippine Constitution mandates the following: Article II Section 15*** for the protection and promotion of the right to health of the people and instills health consciousness among them; and ***(2) Article 13, Section I****I*, which specifies that the state shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all the people at affordable cost. There shall be priority for the needs of the under-privileged, sick, elderly, disabled, women and children. The state shall endeavor to provide free medical care to paupers.
2. ***Republic Act No. 4921,*** extending the Scope of the Cancer Detection and Diagnostic Center of the Dr. Jose Reyes Memorial Hospital to include also Cancer Treatment and Research
3. ***Administrative Order No. 2011-0003***or the National Policy on Strengthening the Prevention and Control of Chronic Lifestyle Related Non Communicable Disease.
4. ***Administrative Order No. 2009-0012***on Guidelines Institutionalizing and Strengthening the Philippine Renal Disease Registry under the DOH.
5. ***Department Memorandum No. 2008-0204***on Collection and Submission of Philippine Renal Disease Registry Forms.
6. ***Administrative Order No. 16-A s. 1995***on Diabetes Mellitus Prevention and Control Program in the Philippines.
7. ***Administrative Order No. 89-A s. 1990****,* ***amendment to A.O. No. 188-A s. 1973*** *on* the Philippine National Cancer Control Program
8. ***Administrative order No. 19 s. 1987*** transferring the functions of the Cancer Control Center to the Jose Reyes Memorial Hospital and to the Non Communicable Disease Control Services
9. ***Administrative Order No. 188-A s. 1973,*** Authority and Functions of the National Cancer Control Center of the DOH
10. ***Administrative Order No. 2007-0010,*** National Policy on Violence and Injury Prevention
11. ***Administrative Order No. 1-B, s. 1997,*** Establishment of a Women and Children Protection Unit in All DOH Hospitals
12. ***Administrative Order No. 16-A, s. 1999*** Guidelines on the Issuance of Certification of Disability to Persons with Disabilities

# OBJECTIVES

The issuance of this Order aims to achieve the following objectives:

1. Provide standard recording and submission of reportable cases related to chronic non-communicable diseases, injuries, violence, and disabilities which are diagnosed or confirmed accordingly to the DOH.
2. Collect data that are essential for public health planning, use, and/or implementation.
3. Establish clear operating guidelines and/or procedures in the implementation of the registry system.
4. Define rules to protect the confidentiality of data.
5. **SCOPE OF APPLICATION**

This Order shall apply to all DOH Central Office, Centers for Health Development Offices, Provincial/District/City/Municipality Health Offices, and government and private clinics and hospitals including medical professional societies/associations.

# LIST OF ACRONYMS

For purposes of this Order, the following terms are defined as follows:

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| 1 | BHFS | Bureau of Health Facilities and Services |
| 2 | COPD | Chronic Obstructive Pulmonary Diseases |
| 3 | DOH | Department of Health |
| 4 | ICNCDRS | Integrated Chronic Non-Communicable Disease Registry |
| 5 | IMS | Information Management Service |
| 6 | NCDPC | National Center for Disease Prevention and Control |
| 7 | NCHFD | National Center for Health Facility Development |
| 8 | NEC | National Epidemiology Center |
| 9 | CHD | Center for Health Development |
| 10 | URS | Unified Registry Systems |
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# DEFINITION OF TERMS

For purposes of this Order, the following terms are defined as follows:

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| --- | --- | --- |
| 1 | Medical Associations | Refer to associations like Medical Societies, Specialty Divisions and Specialty Societies, Affiliate Societies, and other related associations. |
| 2 | Reportable Case | Refers to diagnosed or confirmed chronic non-communicable disease, injury, violence, or disability. |
| 3 | Reporting Health Facilities | Refer to government and private clinics, hospitals, medical societies and other professional organizations with existing information systems. |
| 4 | URS (Unified Registry Systems) | Collection of data related to patients with diagnosed/confirmed cases on chronic non-communicable diseases, injuries, violence, and disabilities. |
| 5 | Confirmed Diagnosis |  |
| 6 | Clinical Diagnosis | Diagnosis based on a study of the signs and symptoms of a disease. (The American Heritage® Medical Dictionary Copyright © 2007, 2004 by Houghton Mifflin Company. Published by [Houghton Mifflin Company](http://www.eref-trade.hmco.com/). All rights reserved. <http://medical-dictionary.thefreedictionary.com/clinical+diagnosis>) |
| 7 | Injury | An injury is the physical damage that results when a human body is suddenly or briefly subjected to intolerable levels of energy. It can be a bodily lesion resulting from acute exposure to energy in amounts that exceed the threshold of physiological tolerance, or it can be an impairment of function resulting from a lack of one or more vital elements (i.e. air, water, warmth), as in drowning, strangulation or freezing. The time between exposure to the energy and the appearance of an injury is short. (INJURY SURVEILLANCE GUIDELINES, Published in conjunction with the Centers for Disease Control and Prevention, Atlanta, USA, by the World Health Organization, 2001) |
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1. **GENERAL GUIDELINES**
2. The Unified Registry Systems serve as tools and mechanisms to collect information on reportable cases on chronic non-communicable diseases, injuries, violence, and disabilities that have been diagnosed or confirmed as such in the country as basis for sound and rational planning, implementation, monitoring and evaluation of health programs; development of health services, health policies and programs, and inputs to studies and other related undertakings.
3. Professional societies and those with existing information systems shall upload the required data to the DOH Information Management Service to generate national data.
4. The security, confidentiality, and integrity of data shall at all times be secured and/or protected.
5. Monitoring shall be conducted by the NCDPC, NEC, and/or IMS in coordination with the NCHFD and BHFS, to evaluate compliance of reporting facilities, strengthen quality assurance, and monitor the performance of the unified registry systems.

# SPECIFIC GUIDELINES

1. Unified Registry Systems’ Reporting

The Unified Registry Systems serve as tools and mechanisms to collect information on reportable cases on chronic non-communicable diseases, injuries, violence, and disabilities that have been diagnosed or confirmed as such in the country as basis for sound and rational planning, implementation, monitoring and evaluation of health programs; development of health services, health policies and programs, and inputs to studies and other related undertakings:

1. Reporting health facilities refer to government and private clinics and hospitals. Said facilities shall report *diagnosed or confirmed* cases of chronic non-communicable diseases like cancer, diabetes, stroke, COPD, renal diseases, blindness, mental health, cardiovascular and other chronic non-communicable diseases; injuries, violence, and disabilities on a regular basis.
2. Regular basis refers to the frequency of reporting, namely:

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| --- | --- | --- |
| i | Chronic Non-Communicable Diseases | Monthly |
| ii | Injuries | Daily |
| iii | Violence | Daily |
| iv | Disabilities | Monthly |

1. When there is a reportable case, the reporting health facility, through the concerned doctor or authorized personnel, shall fill up the appropriate standard recording form. The standard recording forms are as follows:

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| --- | --- | --- |
| i | Cancer Registry Form | Annex 1.0 |
| ii | COPD Registry Form | Annex 2.0 |
| iii | Diabetes Registry Form | Annex 3.0 |
| iv | Stroke Registry Form | Annex 4.0 |
| v | Patient Injury Registry Form | Annex 5.0 |
| vi | Fireworks Injury Surveillance – Patient Information Sheet | Annex 6.0 |
| vii | Violence Against Women and Children – Patient Information Sheet | Annex 7.0 |
| viii | Persons with Disability Registration Form | Annex 8.0 |

1. Reporting health facilities shall use the *Online Data Entry* or *Data Uploading* that is applicable to their current settings, situations, and/or capacities to submit their reportable case to the DOH IMS. The official website address is <http://uhmis1.doh.gov.ph/>UnifiedRegistryNC.
2. For Chronic Non-Com and PWD monthly reporting, the period for entering or uploading data is *every first five (5) working days* of the month. The submitted data shall already be *validated or checked* by the reporting health facilities and considered as *clean and official*.
3. The URS shall be available twenty-four (24) hours per day and seven (7) days a week. In any situation where the URS is unavailable due to problems in the DOH’s Internet Service Provider, database and application servers, and other concerns, an email message shall be sent to all reporting health facilities. Same users shall be notified by email once the URS becomes available.
4. Information Technology support shall be available during working days, i.e. Monday to Friday. Request for issuance of user names and passwords, and other system administration services shall be addressed on the following working day.
5. Data Uploading

Professional societies and those with existing information systems shall upload the required data to the DOH Information Management Service to generate national data..

1. Offices with information systems being funded by the DOH like the Philippine Cancer Society, Renal Disease Control Program, and others *shall upload data* to the DOH IMS.
2. Medical Associations are encouraged to upload data to the DOH Central Office to ensure a coordinated and systematic approach to data collection and analysis of data.
3. Data Dictionaries for Uploading shall be given to standardize the data to ensure interoperability and data sharing.
4. A Memorandum of Agreement between the DOH and those facilities with existing information systems shall be issued for systematic data uploading, confirmation of roles, duties and responsibilities, and commitment to upload the data.
5. Security of Data
6. The security, confidentiality, and integrity of data shall at all times be secured and/or protected.
   1. Each reporting health facility shall only be given one (1) account, i.e. user name and password for close monitoring of compliance and accountability. Heads of Reporting Health Facilities, i.e. Chiefs, Directors, or equivalent, shall disseminate the user names and passwords to their authorized personnel and are held liable or accountable to any misuse or abuse in the use of the accounts.
   2. Users of the URS shall be managed through the System Administration – Users’ Account Function of the system and to be administered by the IMS.
   3. Passwords can be changed by the reporting health facilities but the user names are permanent and cannot be modified.
   4. Reporting facilities shall ensure that the data are validated or checked before uploading. Submitted data cannot be edited or modified. Reporting health facilities have to undergo the following processes to request for editing:
      1. Fill up the Incident Report (Annex 9.0) with the approval signature of the head of the reporting health facility or duly authorized personnel.
      2. Submit the Incident Report to the NCDPC via personal delivery or mail.
      3. Wait for confirmation that the changes or modifications have been done or entered.
   5. Reporting health facilities can only access the data that they submitted, and shall not be able to view the data of other health facilities. A written request for an electronic copy of their submitted data in excel, word, xml, or csv formats shall be required from the Head of the Reporting Health Facilities or duly authorized personnel.
   6. Information about the reportable cases shall be available at a consolidated, summary or statistical level. Personal details are restricted.
   7. DOH personnel handling the URS shall not disclose the contents of the registry or any individually-identifiable information which may have come to his knowledge in the course of performing any duty or function under this Order or carrying any act in relation to this Order. Any person who fails to comply with this shall be guilty of an offense and shall be legally liable.
   8. The NCDPC shall evaluate and approve request for data including individually-identifiable information. In determining whether to approve the request for data or disclosure, the following shall be critically considered:
      1. Objectives of the national public health programs including public health safety and benefits
      2. Use of the data
      3. Identity of the officers or persons to whom the data will be given or disclosed
      4. Measures to protect the data
   9. The URS shall keep an audit trail of all data accesses.
   10. The NCDPC shall suspend, terminate or lift the users’ accounts if any provisions of the procedures or guidelines are violated, or the security, confidentiality or integrity of the systems and/or data is compromised.
7. Monitoring/Evaluation of Registry System

Monitoring shall be conducted by the NCDPC, NEC, and/or IMS in coordination with the NCHFD and BHFS, to evaluate compliance of reporting facilities, strengthen quality assurance, and monitor the performance of the unified registry systems

* 1. The NCDPC in coordination with the NEC and/or IMS shall create and maintain a harmonized standard system monitoring tool and reporting form to be used during monitoring.
  2. Monitoring activities shall be done on a quarterly basis with the following factors to consider in selecting the health facilities to monitor:

1. Non-compliance in reporting data
   * + 1. Irregular reporting of data
       2. Delayed reporting of data
       3. With deficiency findings as validated or assessed by the NCDPC, NEC, and/or IMS.
       4. With verbal or written complaints reported or filed by concerned offices, individuals, or other organizations.
       5. Other factors that may identified during system implementation.
   1. An annual review of the system and its implementation issues shall be conducted to evaluate its performance based from the monitoring conducted quarterly. It shall be conducted with the concerned stakeholders in each registry system.
2. Sanctions for Non-compliance

Administrative Order No. 2011-0020, Section V. Guidelines, A. Streamlining of Licensure and Accreditation of Hospitals, Specific Guidelines, f. Reports, states that “an annual updated consolidated hospital statistical reports shall be prepared by DOH-CO/CHD in accordance with the format posted in at DOH website”. Failure to comply with any of these rules and regulations and its related issuances shall constitute a violation and shall be penalized following Section IV. Guidelines A. Violations and B. Sanctions of A.O. No. 2007-0022 re: “Violations Under the One-Stop Shop Licensure System for Hospitals.”

Data submitted through the Unified Registry Systems can be accessed by the Bureau of Health Facilities and Development and CHDs, and can be included in the required hospital statistical reports.

# ROLES AND RESPONSIBILITIES

1. **Reporting Health Facilities {Government Hospitals (under DOH and Local Government), Private Hospitals, Private Clinics and Professional Societies with existing registry}**
   * 1. Designate full time and backup personnel who shall be responsible for entering or uploading data into the systems.
     2. Enter or upload quality data, i.e. accurate, valid, reliable, and/or timely on a regular basis.
     3. Report erroneous submitted data to the NCDPC for proper correction or editing.
     4. Report problems that are encountered during operations through the online reporting system.
2. **National Center for Disease Prevention and Control**
3. Manages the overall implementation of the registry system including direction and guidance in the continuing operations, system enhancement, and data management.
4. Formulates processes, procedures, policies and guidelines related to the registry system.
5. Addresses issues, concerns, and/or problems accordingly like respond to queries about the forms, reports and standard operating procedures or processes.
6. Formulates policies, procedures, guidelines, and relevant protocols to ensure continuous operations, and develops program interventions as needed.
7. Validates data according to agreed level of validation to confirm its quality.
8. Reviews management, statistical, and other reports with the end objective of providing the necessary recommendations or comments.
9. Compiles and publishes reports on non-communicable diseases data.
10. Provides funds to support studies/researches as a result of data findings.
11. The NCDPC in collaboration with the concerned specialty societies shall analyze and interpret the data generated from the system.
12. **National Epidemiology Center**
13. Support the development of processes, procedures, policies and guidelines related to the registry system.
14. Addresses issues, concerns, and/or problems accordingly.
15. Assists in the formulation of policies, procedures, guidelines, and relevant protocols to ensure continuous operations, and develops program interventions as needed.
16. Reviews management, statistical, and other reports with the end objective of providing the necessary recommendations or comments.
17. Validates data according to agreed level of validation to confirm its quality.
18. Provides funds to support studies/researches as a result of data findings.
19. Monitors the implementation of the system.
20. Supervise data management.
21. **Information Management Service**
22. Maintains the registry software.
23. Addresses technical problems accordingly.
24. Trains users on how to operate the registry system.
25. Assists in the formulation of policies, procedures, guidelines, and relevant protocols to ensure continuous operations, and develops program interventions as needed.
26. Performs database and network management activities.
27. Manages the help desk support to ensure continuous operations.
28. Provides funding on information and communication technology resources based on the DOH Information System Strategic Plan or other DOH directives or issuances.
29. **National Center for Health Promotion**
    1. Translates the salient findings into messages and materials that are appropriate for specific population segments.
    2. Conducts communication activities through various media channels to elicit public opinion and generate public discussion favorable to disease prevention and control.
30. **National Center for Health Facility Development and Bureau of Health Facilities and Services**
31. Provides implementation support like developing guidelines and policies to ensure continuous compliance of hospitals to this directive.
32. Monitors the implementation of the system operation.
33. **Center for Health Development**
34. Ensure timely entry or uploading of quality data into the registry system.
35. Report erroneous data for correction or editing using the Incident Report Form.
36. Report problems that are encountered during operations.
37. Participate in the evaluation of the registry system to further improve the functionalities or performance of the system.
38. **Provincial Health Office, District Health Office and Municipal Health Office**
39. Provides implementation support to ensure continuous compliance of to this directive.
40. **Professional Societies (includes medical, nursing, and other paramedical societies), Development Partners and Private Organizations**
41. Professional societies with existing information systems shall upload the required data to the DOH Information Management Service to generate national data.
42. Provide expert inputs on the analysis and interpretation of the data gathered from the registries.
43. Participate in the evaluation of the registry system to further improve the functionalities or performance of the system.

# REPEALING CLAUSE

Provisions from previous issuances that are inconsistent or contrary to the provisions of this Order are hereby rescinded and modified accordingly.

# SEPARABILITY

If any provision of this Order is declared invalid, the other provisions not affected thereby shall remain valid and subsisting.

1. **EFFECTIVITY**

This order shall be effective immediately.

**ENRIQUE T. ONA, MD, FPCS, FACS**

Secretary of Health

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| **Office** | **NCDPC** | **NEC** | **IMS** | **NCHFD** | **BHFS** | **HPDPB** | **SSDTC** |
| **Initial** |  |  |  |  |  |  |  |
| **Date** |  |  |  |  |  |  |  |

**Annex 1.0 Cancer Registry Form**

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CANCER Registry Form

***Note: Please put N/A for Not Applicable fields.***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **GENERAL DATA** | | | | | | | | | | | | | | | | | | | | | | | |
| 1 **Name of Reporting Health Facility**  **(SYSTEM GENERATED)** | | | | | | | | 2 **Hospital Patient ID No.** | | | | | | 3 **Hospital Registry No.** | | | | 4**Hospital Case No.** | | | | | 5 **National Registry No.**  **(SYSTEM GENERATED)** |
| 6 **Type of Patient**  ⭘ OPD  ⭘ In- Patient | | | | | | | | |  | | --- | | 7 **Name of Patient**  **\_\_\_\_\_\_\_\_\_,\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_**  Last Name First Name Middle Name | | | | | | | | | | 8**Sex**  ⭘Female  ⭘ Male | | | | | 9**Civil Status**  ⭘ Single ⭘Married  ⭘ Widow/er  ⭘ Separated  ⭘ Co-Habitation | |
| 10**Mother’s Maiden Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last Name First Name Middle Name | | | | | | | | | | | | | | | | | | | | | | | |
| 11**Permanent Address**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_**  Number & Street Name Region Province City/Municipality Barangay | | | | | | | | | | | | | | | | | | | | | | | 12**PhilHealth #** |
| 13**Birth Date**  **\_\_\_\_/\_\_\_\_/\_\_\_\_**  mm ddyyyy | | | 14**If Date of Birth is not available**  \_\_Yrs \_\_ Mos \_\_ Days | | | | | | | 15 **Place of Birth** (Province, City/Municipality) | | | | | | | | 16**Landline #** | | | | | 17**Mobile #** |
| 18 **Religion** | 19**Nationality** | | | | 20**Race** | | | | 21**Ethnicity** | | 22 **Occupation** | | | | 23. **Company** | | | | | | 24.**Highest Educ. Attain.** | | |
| **PATIENT HISTORY** | | | | | | | | | | | | | | | | | | | | | | | |
| 25.⭘ **Smoking**   1. No. of Years of Smoking: \_\_\_\_\_ 2. Year Started Smoking: \_\_\_\_\_   26. ⭘ **Physical Activity**   1. Kind**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** 2. Minutes per Day: \_\_\_\_\_\_\_\_\_\_\_ 3. Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | 27.⭘ **Diet Intake**   1. ⭘ Meat and meat products, specify \_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency\_\_\_\_\_\_\_\_\_\_\_\_   1. ⭘ Carbohydrates, specify \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency \_\_\_\_\_\_\_\_\_\_\_\_   1. ⭘ Fruits/Vegetables, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Frequency \_\_\_\_\_\_\_\_\_\_\_ d. ⭘ Others, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | 28.⭘.**Drinking of Alcohol/Beverage**  a. Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  b. Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  c. Unit of Measure: \_\_\_\_\_\_\_\_  d. Frequency: \_\_\_\_\_\_\_\_\_\_\_\_  29⭘**Chemical Exposure, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| 30. **Number of sexual partners** | | | | | | | | 31.⭘.**Early Age of Sexual Intercourse** | | | | | | | | | | | | | | | |
| 32.⭘.**Use of contraceptive and number of years of use of drug, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | |
| 33.⭘.**Family History/Cancer**  **Family Member Specify**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | 33a.**Height in Meter**  33b.**Weight in Kilograms** | | | | | 34a.**Body Mass Index**  34b.**Classification (BMI)** | | | | | | | 35a.**Waist circumference in centimeters**  36b.**Classification (WC)** | | | |
| 37 **Infections Agent**   1. ⭘ Human Papilloma Viruses write year examined \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. ⭘Helicobacter Pylori write year examined\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. ⭘ Hepatitis B or C Virus write year examined\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. ⭘ Epsteim – Barr Virus 5. ⭘ HIV | | | | | | | | | | | | | | | | | | | | | | | |
| **CANCER DATA** | | | | | | | | | | | | | | | | | | | | | | | |
| 38.⭘.**Referred From** | | | | 39.**Name of Referring Health Facility** | | | | | | | | | | | | 40.**Reason for Referral** | | | | | | | |
| 41.**Date of Consultation**  **\_\_\_\_/\_\_\_\_/\_\_\_\_\_**  mm ddyyyy | | | | 42.**Chief Complaint:** | | | | | | | | | | | | | | | 43.**Date of Diagnosis**  **\_\_\_\_/\_\_\_\_/\_\_\_\_\_**  mm dd yyyy | | | | |
| 44 **Most Valid Diagnosis**  ⭘ **Non-Microscopic:** 🞎Death Certificates Only 🞎Clinical Investigation 🞎Clinical Only 🞎Specific Tumor Markers  ⭘ **Microscopic :** 🞎Cytology or Hematology 🞎Histology of Metastasis 🞎Histology of Primary  ⭘ **Unknown** | | | | | | | | | | | | | | | | | | | | | | | |
| 45**Multiple Primaries**  ⭘1 ⭘2 ⭘3 | | 46**Primary Sites 🡪**🞎Brain 🞎Bladder ⭘ Urinary ⭘ Gall 🞎Breast 🞎Colon 🞎Corpus Uteri 🞎Esophagus 🞎Kidney 🞎Larynx 🞎Blood 🞎Liver 🞎Lung 🞎Skin 🞎Nasopharynx 🞎Oral Cavity 🞎Ovary 🞎Pancreas 🞎Prostate 🞎Rectum 🞎Stomach 🞎Testis 🞎Thyroid  🞎Uterine Cervix 🞎Others, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |
| 47**Laterality:**  ⭘Left ⭘Right  ⭘Bilateral ⭘Mid ⭘Not Stated | | | | | | | 48.**Histology (Morphology)** | | | | | | | | | | | 49.**TNM System**  **T\_\_\_\_\_\_\_\_N\_\_\_\_\_\_\_\_M\_\_\_\_\_\_\_\_** | | | | | |
| 50.**Staging** ⭘In-Situ ⭘Localized ⭘Direct Extension ⭘Regional Lymph Node ⭘3+4 ⭘Distant Metastasis ⭘Unknown  51.**Sites of Distant Metastasis**  🞎None 🞎Distant Lymph Nodes 🞎Bone 🞎Liver 🞎Lung (Pleura) 🞎Brain 🞎Ovary 🞎Skin 🞎Other 🞎Unknown | | | | | | | | | | | | | | | | | | | | | | | |
| 52**Final Diagnosis** | | | | | | | | | | | | 53.**Final Diagnosis: ICD-1O Code** | | | | | | | | | | | |
| 54.**Treatment** 🞎Surgery 🞎Radiotherapy 🞎Chemotherapy 🞎 Immunotherapy/Cryotherapy 🞎Hormonal 🞎Unknown  🞎Others, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | |
| 55.**Patient Status** ⭘ Recovered ⭘ Improved ⭘ Unimproved ⭘Died | | | | | | | | | | | | | | | | | | | | | | | |
| 56.**If died, underlying Cause of Death** | | | | | | | | | | | | 57**If died, underlying Cause of Death: ICD-1O Code** | | | | | | | | | | | |
| 58.**Date of Death (**mm/dd/yyyy) **\_\_\_\_/\_\_\_\_/\_\_\_\_\_** | | | | | | 59.**Place of Death** | | | | | | 60 .**Disposition**  ⭘ Admitted  ⭘ Discharged  ⭘ Transferred  ⭘ Discharge Against Medical Advice  ⭘ Treated and Sent Home  ⭘ Absconded | | | | | | | | | | | |
| 61.**If Transferred, Name of Health Facility** | | | | | | | | | | | | | | | | 62.**Reason for Referral** | | | | | | | |
| 63. **Completed By** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last Name First Name Middle Name Designation | | | | | | | | | | | | | | | | 64.**Date Completed \_\_\_\_/\_\_\_\_/\_\_\_\_**  mm dd yyyy | | | | | | | |

**Annex 2.0 COPD Registry Form**

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Chronic Obstructive Pulmonary Disease (COPD) Registry Form

***Note: Please put N/A for not applicable fields.***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **GENERAL DATA** | | | | | | | | | | | | | | | | | | | |
| 1 **Name of Reporting Health Facility**  **(SYSTEM GENERATED)** | | | | | | 2 **Hospital Patient ID No.** | | | 3 **Hospital Registry No.** | | | | | 4 **Hospital Case Number** | | | | 5 **National Registry No.**  **(SYSTEM GENERATED)** | |
| |  | | --- | | 7 **Name of Patient**  **\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_** Last Name First Name Middle Name |   6 **Type of Patient**  ⭘ OPD  ⭘ In- Patient | | | | | | | | | | | | | | | 8**Sex**  ⭘ Female  ⭘ Male | | | 9**Civil Status**  ⭘ Single ⭘ Married⭘ Widow/er⭘ Separated  ⭘Co-Habitation | |
| 10**Mother’s Maiden Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last Name First Name Middle Name | | | | | | | | | | | | | | | | | | | |
| 11 **Permanent Address**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_**  Number & Street Name Region Province City/Municipality Barangay | | | | | | | | | | | | | | | | | | | 12**PhilHealth #** |
| 13**Birth Date**  **\_\_\_\_/\_\_\_\_/\_\_\_\_**  mm ddyyyy | | 14**If Date of Birth is not available**  \_\_Yrs \_\_ Mos \_\_ Days | | | | | 15 **Place of Birth** (Province & City/Municipality) | | | | | | | | 16**Landline #** | | | 17**Mobile #** | |
| 18**Religion** | 19**Nationality** | | | 20**Race** | | | 21 **Ethnicity** | | | 22 **Occupation** | | | | | 23 **Company** | | | 24**Highest Educ. Attain.** | |
| **PATIENT HISTORY** | | | | | | | | | | | | | | | | | | | |
| 25⭘**Smoking**  ⭘ Less than/Equal to 1 pack  consumed per day  ⭘ More than 1 pack consumed/day  Number of Years Smoking: \_\_\_\_\_\_\_ | | | | | | | | 26⭘**Second Hand Smoke (SHS)**  ⭘ With Exposure to SHS  Number of Years: \_\_\_\_\_\_ | | | | | | | | 27⭘**Occupational Exposure**  🞎Cement Dust 🞎Cotton  🞎Grains 🞎Metal  🞎Paper Mill 🞎Silica  🞎Others, specify \_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| 28⭘**Pulmonary Infections**  🞎TB 🞎Others, specify \_\_\_\_\_\_\_\_\_\_ | | | | | | | | 29⭘**Indoor Air Pollution**  Type of Indoor Air Pollutant  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | 30⭘**Outdoor Air Pollution**  Type of Outdoor Air Pollutant  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **COPD DATA** | | | | | | | | | | | | | | | | | | | |
| 31**Type of COPD, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | |
| 32⭘ **Referred From** | | | 1. **Name of Referring Health Facility** | | | | | | | | | | | | 33**Reason for Referral** | | | | |
| 34**Date of Consultation (**mm/dd/yyyy) **\_\_\_\_/\_\_\_\_/\_\_\_\_\_** | | | | | | | | | | | | 35**Date of Diagnosis (**mm/dd/yyyy) **\_\_\_\_/\_\_\_\_/\_\_\_\_\_** | | | | | | | |
| 36**Symptoms 🡪**🞎Chest Tightness 🞎Chronic Cough 🞎Clubbing of the Fingers 🞎Cyanosis 🞎Dyspnea  🞎Frequent Chest Infections 🞎 Hemoptysis 🞎Increase in Sputum Production 🞎Wheezing  🞎Others, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| 37 **Treatment**🡪🞎Bronchodilator 🞎Corticosteroids 🞎Combination Corticosceroids – long Acting Beta 2-agonis  🞎Mucolytics 🞎Antibiotics 🞎Others, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| 38**Status of Severity** 🡪🞎At Risk  🞎Mild COPD (FEV.>=80%)  🞎Moderate COPD (FEV. >=50% but <80% predicted)  🞎Severe COPD (FEV.>=30% but 50% predicted)  🞎Very Severe COPD (FEV. <50% with Respiratory Failure or Clinical Signs of Right Heart Failure)  🞎Unknown | | | | | | | | | | | | | | | | | | | |
| 39.**Final Diagnosis: POST BRONCHODILATOR FEV/FVC < 70% \_\_\_\_\_\_\_\_\_\_\_\_\_\_(Spirometry)** | | | | | | | | | | | | | | | | | | | |
| 40.**Final Diagnosis: ICD-1O Code** | | | | | | | | | | | | | | | | | | | |
| 41.**Patient Status**⭘Recovered⭘Improved⭘Unimproved ⭘Died | | | | | | | | | | | | | | | | | | | |
| 42.**If died, underlying Cause of Death** | | | | | | | | | | | 43.**If died, underlying Cause of Death: ICD-1O Code** | | | | | | | | |
| 44**Date of Death (**mm/dd/yyyy) **\_\_\_\_/\_\_\_\_/\_\_\_\_\_** | | | | | 45.**Place of Death** | | | | | | 46.**Disposition**  ⭘ Admitted  ⭘ Discharged  ⭘ Transferred  ⭘ Discharge Against Medical Advice  ⭘ Treated and Sent Home  ⭘ Absconded | | | | | | | | |
| 47.**If Transferred, Name of Health Facility** | | | | | | | | | | | | | 48.**Reason for Referral** | | | | | | |
| 49.**Completed By** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last Name First Name Middle Name Designation | | | | | | | | | | | | | | | | | 50**Date Completed**  **\_\_\_\_/\_\_\_\_/\_\_\_\_** | | |

**Annex 3.0 Diabetes Registry Form**

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DIABETES Registry Form

***Note: Please put N/A for not applicable fields.***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **GENERAL DATA** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 **Name of Reporting Health Facility**  **(SYSTEM GENERATED)** | | | | | | | | | | | 2 **Hospital Patient ID No.** | | | | 3 **Hospital Registry No.** | | | | | | | 4**Hospital Case No.** | | | | | | 5 **National Registry No. (SYSTEM GENERATED)** | |
| |  | | --- | | 7 **Name of Patient**  **\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_** Last Name First Name Middle Name |   6 **Type of Patient**  ⭘ OPD  ⭘ In-Patient | | | | | | | | | | | | | | | | | | 8**Sex**  ⭘ Female  ⭘ Male | | | | | | | 9**Civil Status**  ⭘Single ⭘Married⭘ Widow/er⭘Separated  ⭘ Co-Habitation | | | | |
| 10 **Mother’s Maiden Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last Name First Name Middle Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11 **Permanent Address**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_  Number & Street Name Region Province City/Municipality Barangay | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 12**PhilHealth #** |
| 13**Birth Date**  \_\_\_\_/\_\_\_\_/\_\_\_\_ | | 14**If Date of Birth is not available**  \_\_Yrs \_\_ Mos \_\_ Days | | | | | | | | | | 15 **Place of Birth** (Province & City/Municipality) | | | | | | | | | | | 16**Landline #** | | | | | | 17**Mobile #** |
| 18**Religion** | 19**Nationality** | | | 20**Race** | | | | 21**Ethnicity** | | | | | 22 **Occupation** | | | | | | | 23 **Company** | | | | | | 24**Highest Educ. Attain.** | | | |
| **PATIENT HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25⭘**Smoking**   1. No. of Years of Smoking:\_\_\_ 2. Year Started Smoking: \_\_\_   29⭘**Physical Activity**   1. Kind**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** 2. Minutes per Day: \_\_\_\_\_\_\_\_ 3. Frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | 27⭘**Diet Intake**   1. ⭘ Meat and meat products, specify \_\_\_\_\_\_\_\_\_\_\_\_ Frequency\_\_\_\_\_\_\_\_\_\_\_\_ 2. ⭘ Carbohydrates, specify \_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_ Frequency \_\_\_\_\_\_\_\_\_\_\_\_   1. ⭘ Fruits/Vegetables, specify \_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_Frequency \_\_\_\_\_\_\_\_\_\_\_\_   1. ⭘ Others, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_ Frequency \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | 28⭘**Drinking of Alcohol/Beverage**  a. Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  b. Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  c. Unit of Measure: \_\_\_\_\_\_\_\_\_  d. Frequency: \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **DIABETES DATA** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30.⭘.**Referred From** | | | 31 **Name of Referring Health Facility** | | | | | | | | | | | | | | | | | | 32**Reason for Referral** | | | | | | | | |
| 31 **Date of Consultation** \_\_\_\_/\_\_\_\_/\_\_\_\_  mm ddyyyy | | | | | | | | | | 32a **Height in Meter**  32b **Weight in Kilograms** | | | | | | 33a **Body Mass Index**  33b **Classification (BMI)** | | | | | | | | | | | 34a **Waist Circumference in centimeters**  34b **Classification (WC)** | | |
| 35 **Physiological Status for Females 🡪**⭘ Pregnant ⭘ Lactating ⭘Not Applicable | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 36 **Signs and Symptoms 🡪🞎** Polyuria **🞎** Polydipsia **🞎** Polyphagia **🞎** Weight Loss **🞎** Tingling Sensation  **🞎** Non-Healing Wound **🞎** Others, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 37 **Newly or Previously Diagnosed Diabetes:**⭘ Newly Diagnosed ⭘ Previously Diagnosed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 38 **Date of Diagnosis**: \_\_\_\_/ \_\_\_\_/ \_\_\_\_  mm ddyyyy | | | | | | | | | 39a. Health Facility Where Diagnosed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  39b. Tests Conducted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  39c. Duration of Diabetes: \_\_\_\_\_\_ ⭘ Days ⭘ Weeks ⭘Months ⭘Years  39d. Age at Diagnosis: In Years: \_\_\_\_ In Months \_\_\_\_\_ In Days \_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | |
| 40.a **Type of Diabetes** ⭘ Type 1 ⭘ Type 2 ⭘ GDM ⭘ IGT/IFG ⭘ Other, Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  40.b **Complications** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 41. **Current Treatment**  a.1⭘ **Medical Nutrition Therapy**  ⭘ With Formal Consult/Education  ⭘ No Formal Consult/Education  a.2.⭘ **Compliance**  ⭘ Yes ⭘ No | | | | | | | 1. **Physical Activity**   Kind \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Frequency per Week \_\_\_\_\_ | | | | | | | | | | c.⭘ **Oral Hypoglycemic**  ⭘ Sulfonylurea  ⭘ Metformin  ⭘ Acarbose  ⭘ TZD  ⭘ Others, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |
| d. ⭘ **Insulin**  | Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Units per Day \_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |
| 42 **Surgeries/Operations 🡪🞎** Amputation | ⭘ Digital ⭘ BKA  **🞎** Revascularization **🞎** Others, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 43. **Family Diseases 🞎** Hypertension **🞎** CVD **🞎** Stroke **🞎** Cancer **🞎** Asthma **🞎** TB **🞎** Diabetes  **🞎** Others, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  44. If with Diabetes, **Family Members Diagnosed**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 45.a **OB GYNE HISTORY:** No. of Babies >= 8 lbs. \_\_\_\_\_\_\_\_\_ 45.b **OB GYNE HISTORY:** No. of Babies with Congenital  Anomalies \_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 46. **Final Diagnosis** | | | | | | | | | | | | | | 47. **Final Diagnosis: ICD-1O Code** | | | | | | | | | | | | | | | |
| 48. **Patient Status**⭘ Recovered ⭘ Improved ⭘ Unimproved ⭘ Died | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 49. **If died, underlying Cause of Death** | | | | | | | | | | | | | | 50 **If died, underlying Cause of Death: ICD-1O Code** | | | | | | | | | | | | | | | |
| 51.**Date of Death(**mm /dd/yyyy)  **\_\_\_\_/\_\_\_\_/\_\_\_\_\_** | | | | | 52 **Place of Death** | | | | | | | | | 53 **Disposition**  ⭘ Admitted  ⭘ Discharged  ⭘ Transferred  ⭘ Discharge Against Medical Advice  ⭘ Treated and Sent Home  ⭘ Absconded | | | | | | | | | | | | | | | |
| 54. **If Transferred, Name of Health Facility** | | | | | | | | | | | | | | | | | | | 55 **Reason for Referral** | | | | | | | | | | |
| 56. **Completed By** \_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ , \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last Name First Name Middle Name Designation | | | | | | | | | | | | | | | | | | | 57 Date Completed \_\_\_\_/\_\_\_\_/\_\_\_\_  mm dd yyyy | | | | | | | | | | |

**Annex 4.0 Stroke Registry Form**

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STROKE Registry Form

***Note: Please put N/A for not applicable fields.***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **GENERAL DATA** | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 **Name of Reporting Health Facility**  **(SYSTEM GENERATED)** | | | | | | | | 2 **Hospital Patient ID No.** | | | | | | 3 **Hospital Registry No.** | | | | 4 **Hospital Case Number** | | | | | 5 **National Registry No.**  **(SYSTEM GENERATED)** | |
| |  | | --- | | 7 **Name of Patient**  **\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_ , \_\_\_\_\_\_\_\_\_\_\_\_**  Last Name First Name Middle Name |   6 **Type of Patient**  ⭘ OPD  ⭘ In- Patient | | | | | | | | | | | | | | | 8**Sex**  ⭘ Female  ⭘ Male | | | | | | 9**Civil Status**  ⭘ Single ⭘ Married ⭘Widow/er⭘Separated  ⭘Co-Habitation | | | |
| 10**Mother’s Maiden Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last Name First Name Middle Name | | | | | | | | | | | | | | | | | | | | | | | | |
| 11 **Permanent Address**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_**  Number & Street Name Region Province City/Municipality Barangay | | | | | | | | | | | | | | | | | | | | | | | | 12**PhilHealth #** |
| 13**Birth Date**  \_\_\_\_/\_\_\_\_/\_\_\_\_  mm ddyyyy | | 14**If Date of Birth is not available**  \_\_Yrs \_\_ Mos \_\_ Days | | | | | | | | 15 **Place of Birth** (City/Municipality & Province) | | | | | | | | | 16**Landline #** | | | | | 17**Mobile #** |
| 18**Religion** | 19**Nationality** | | | | 20**Race** | | | | 21 **Ethnicity** | | | 22 **Occupation** | | | | 23. **Company** | | | | | | 24.**Highest Educ. Attain.** | | |
| **PATIENT HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | |
| 25.⭘**Smoking**  a. No. of Years of Smoking: \_\_\_   1. Year Started Smoking: \_\_\_   26.⭘**Physical Activity**   1. Kind**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** 2. Minutes per Day: \_\_\_\_\_\_\_\_ 3. Frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | 27. ⭘ **Diet Intake**   1. ⭘ Meat and meat products, specify \_\_\_\_\_\_\_\_\_\_\_ Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. ⭘ Carbohydrates, specify \_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_ Frequency \_\_\_\_\_\_\_\_\_\_\_\_\_   1. ⭘ Fruits/Vegetables, specify \_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_Frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. ⭘ Others, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_ Frequency \_\_\_\_\_\_\_­\_\_\_\_\_\_ | | | | | | | | | | | | | 28.⭘.**Drinking of Alcohol/Beverage**  a. Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  b. Amount:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  c. Unit of Measure: \_\_\_\_\_\_\_\_  d. Frequency: \_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| 29**Diseases/Attacks**  🞎 Diabetes Mellitus 🞎HPN 🞎 Transient Ischemic Attacks 🞎 Valvular Diseases (RHD)  🞎Others, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| **STROKE DATA** | | | | | | | | | | | | | | | | | | | | | | | | |
| 30.⭘**Referred From** | | | 31**Name of Referring Health Facility** | | | | | | | | | | | | | 32.**Reason for Referral** | | | | | | | | |
| 33.**Date of Consultation (**mm/dd/yyyy) \_\_\_**/\_\_\_/\_\_\_\_** | | | | | | | | | | | 34.**Date of Confinement (**mm/dd/yyyy) \_\_\_**/\_\_\_/\_\_\_\_** | | | | | | | | | | | | | |
| 35.**Types**  ⭘ Ischemic  ⭘ Hemorrhagic | | | | 36.**Symptoms**  🞎 Weakness 🞎Slurred Speech 🞎 Headache  🞎 Difficulty in Swallowing 🞎 Loss of Vision 🞎 Loss of consciousness  🞎 Numbness or Part Paralysis  🞎 Face 🞎 Arm 🞎 Leg 🞎 Others, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞎 Others, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | |
| 37. **Treatment**  ⭘ Acute Treatment ⭘ Preventive Treatment ⭘For Hemorrhagic Stroke  🞎 Clot Busters tPA 🞎 Anticoagulants/Antiplatelets 🞎 Surgical Intervention  🞎 Others, specify 🞎 Carotid Endarterectomy 🞎 Endovascular Procedures  🞎 Angioplasty/Stents 🞎 Others, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Others, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ⭘ Others, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| 38.**Final Diagnosis** | | | | | | | | | | | | | 39.**Final Diagnosis: ICD-10 Code** | | | | | | | | | | | |
| 40.**Patient Status** ⭘ Recovered ⭘ Improved ⭘ Unimproved ⭘Died | | | | | | | | | | | | | | | | | | | | | | | | |
| 41.**If died, underlying Cause of Death** | | | | | | | | | | | | | 42.**If died, underlying Cause of Death: ICD-1O Code** | | | | | | | | | | | |
| 43**Date of Death (**mm/dd/yyyy) **\_\_\_\_/\_\_\_\_/\_\_\_\_\_** | | | | | | 44.**Place of Death** | | | | | | | 45.**Disposition** ⭘ Admitted  ⭘ Discharged  ⭘ Transferred  ⭘ Discharge Against Medical Advice  ⭘ Treated and Sent Home  ⭘ Absconded | | | | | | | | | | | |
| 46.**If Transferred, Name of Health Facility** | | | | | | | | | | | | | | | | | 47.**Reason for Referral** | | | | | | | |
| 48.**Completed By** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last Name First Name Middle Name Designation | | | | | | | | | | | | | | | | | 49. **Date Completed**  **\_\_\_\_/\_\_\_\_/\_\_\_\_**  mm ddyyyy | | | | | | | |

**Annex 5.0 Patient Injury Registry Form**

Draft Combined Revised Copy: August 26, 2011

**DEPARTMENT OF HEALTH**

**National Electronic Injury Surveillance System**

**Patient Injury Registry Form**

**ER**   **OPD \_\_** New case \_\_ Revisit **In-Patient (injury sustained during confinement)**

**BHS**  **RHU**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **GENERAL DATA** | | | | | | | | | | |
| **(1) Registry No.:** (Not to be filled in- computer generated) | | | | | | | **(2) Hospital/Facility No.:** | | | |
| **(2a) Informant:**  Self (Patient/Injured)  Family member  Police  Others, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  None | | | | | | | | | | |
| **(3) Patient Name** | **Last Name:** | | | | | | **First Name:** | | | **Middle Name:** |
| **(4) Address:** | **House No. & Street:** | | | **Barangay:** | | | **Municipality/City:** | | | **Province:** |
| **(5) Sex:** Female Male  **(6) Nationality: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **(6a) Occupation:**  None/Unemployed  Student  Unknown  Others, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | **(7) Date of Birth:**  \_\_ \_\_/ \_\_ \_\_ / \_\_\_\_\_\_\_\_\_\_  mm dd yyyy  **If Date of Birth is not available, Age in:**  \_\_ years \_\_\_ months \_\_days | | | | | **(7a) Civil Status**  Single Married  Live-in Widowed  Separate | | |
| **PRE-ADMISSION DATA: (also applicable for BHS/RHU cases)** | | | | | | | | | | |
| **(8) Place of Injury:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Street, Barangay**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Municipality/City**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Province**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Region** | | **(9) Date of Injury:**  \_\_ \_\_/ \_\_ \_\_ / \_\_\_\_\_\_\_  **mm dd yyyy**  **(10) Time of Injury:**  **\_\_\_\_\_\_\_\_\_\_\_\_ hr**  **(military time to be entered)** | | | | **(11) Date of Consult:**  \_\_ \_\_/ \_\_ \_\_ / \_\_\_\_\_\_\_\_  **mm dd yyyy**  **(12) Time of Consult:**  **\_\_\_\_\_\_\_\_\_\_\_\_ hr**  **(military time to be entered)** | | | **(13) Injury Intent:**  Unintentional/Accidental  Intentional(violence)  VAWC Patient  Yes  No  Intentional(self-inflicted)  Undetermined  (13a) First Aid Given:  Yes, What: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  By whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Unknown | |
| **(14) Nature of Injury/ies:** | | | | | | | | | | |
| **Multiple injuries?**  **Yes**  **No**  **(Check all applicable, indicate in the blank space opposite each type of injury the body location (site) affected and other details)**  Abrasion \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Avulsion \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Burn (Degree of Burn & Extent of Body Surface involved) Degree:\_\_ 1st \_\_ 2nd  \_\_ 3rd \_\_ 4th  Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Concussion \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contusion \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Fracture  Closed type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (ex. comminuted, depressed fracture)  Open type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (ex. Compound, infected fracture)  Open wound/ Laceration\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (ex. hacking, gunshot, stabbing, animal(dog, cat, rat, snake, etc) bites, human bites, insect bites, punctured wound, etc)  Traumatic Amputation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Others: Pls. specify injury and the body part/s affected:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| **(15) External Cause/s of Injury/ies:** | | | | | | | | | | |
| Bites/stings, Specify animal/insect: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Gunshot, specify weapon \_\_\_\_\_\_\_\_\_\_  Burns, \_\_ Heat \_\_ Fire \_\_ Electricity \_\_ Oil \_\_ Friction \_\_ Others, specify \_\_\_\_\_\_\_\_  Hanging/Strangulation  Chemical/substance, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mauling/Assault  Contact with sharp objects, specify object \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Transport /Vehicular Accident  Drowning: Type/Body of Water: \_\_ Sea \_\_ River \_\_ Lake \_\_ Pool \_\_ Bath Tub \_\_ Others: , specify: \_\_\_\_\_\_\_\_\_\_\_\_  Exposure to forces of nature: \_\_ Earthquake \_\_ Volcanic eruption \_\_ Hurricane \_\_Landslide/Avalanche \_\_Tidal wave  \_\_Flood(due to storm/excessive rain) \_\_ Others, specify \_\_\_\_\_\_\_\_  Fall , specify, from/in/on/into\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Firecracker, specify types/s\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (with libraries)  Sexual Assault/ Sexual Abuse/ Rape (Alleged)  Others, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **(15 a) FOR TRANSPORT/VEHICULAR ACCIDENT ONLY:**  Land  Water  Air  Collision  Non-Collision  **Severity:**  Fatal Accident  Serious Injury Accident  Minor Injury Accident  Property Damage Only  **(15 a.1) Vehicles Involved:**  **Patient’s Vehicle**  None (Pedestrian)  Car  Van  Bus  Motorcycle  Bicycle  Tricycle  Others, \_\_\_\_\_\_\_  unknown  **Other Vehicle/Object Involved**  None (Pedestrian)  Car  Van  Bus  Motorcycle  Bicycle  Tricycle  Others, \_\_\_\_\_\_\_  unknown  (for COLLISION accident ONLY)    **(15 a.2) Position of**  **Patient**  Pedestrian  Driver  Front passenger  Rear passenger  Others, \_\_\_\_\_\_\_  unknown    **(15 a.3) Victims Involved**   Alone  With others, specify how many (excluding the victim). \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| **(15 b) Place of Occurrence:**  Home  School  Road Videoke Bars  Workplace, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Others, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Unknown | | | | | **15 c) Activity of the Patient at the time of the incident:**  Sports  Leisure  Work related  Others, \_\_\_\_\_\_\_\_\_\_\_  Unknown | | | | | |
| **(15 d) Other risk factors at the time of the incident:**  Alcohol/liquor  Smoking Using mobile phone  Sleepy  Others, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (e.g. suspected under the influence of substance used) | | | | | **(15 e) Safety:** (check all that apply)  None  Airbag  Helmet  Childseat  Seatbelt  Life vest/Lifejacket/Floatation device (for drowning)  Others, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Unknown | | | | | |
| **HOSPITAL /FACILITY DATA:**  **A. ER /OPD/BHS/RHU** | | | | | | | | | | |
| **(16) Transferred from another hospital/facility**  Yes  No  (16a) Referred by another Hospital /Facility for Laboratory  and/or other medical procedures  Yes  No | | | | | (**17) Name of Originating Hospital/Physician** : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **(18) Status upon reaching Facility/Hospital**  Dead on Arrival Alive : If alive, please check if: \_\_\_ Conscious \_\_\_ Unconscious  (18a) Mode of transport to the Hospital/Facility:  Ambulance  Police vehicle  Private vehicle  Others, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| 1. **Initial Impression: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   **(20) ICD-10 Code/s: Nature of Injury :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **(21) ICD-10 Code/s: External cause of Injury:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (21a) Treatment Given :  Yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  **(22) Outcome  Improved  Unimproved  Died**  **(23) Disposition**  Admitted  Sent Home  Transferred to another facility/hospital, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  HAMA  Absconded  Died | | | | | | | | | | |
| **B. IN-PATIENT (for admitted hospital cases only)** | | | | | | | | | | |
| **(24) Complete Final Diagnosis:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (**25) Disposition**   Sent Home  Transferred  HAMA  Absconded  Died  **(26) Outcome**   Improved  Unimproved  Died  **(27) ICD-10 Code/s: Nature of Injury :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **(28) ICD-10 Code/s: External cause of Injury:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |

**Comments:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prepared by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Printed Name and Signature

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Annex 6.0 Fireworks Injury Surveillance – Patient Information Sheet**

**DEPARTMENT OF HEALTH**

Draft APIR Form: December 5, 2011

**Fireworks Injury Surveillance**

**Patient Information Sheet**

|  |  |  |
| --- | --- | --- |
| **Date:** | **Region:** | **Hospital:** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PATIENT DATA** | | | | |
| **Patient’s Name: Last Name: First Name: Middle Name:** | | | | |
| **Address: House No. & Street: Barangay: Municipality/City: Province:** | | | | |
| **Telephone No.:** | **Sex:**  Male  Female | **Age in:**    Years \_\_\_\_\_\_ Months \_\_\_\_\_\_ Days \_\_\_\_\_\_ | | |
| **INCIDENT INFORMATION** | | | | |
| **Date of Injury:** **Time of Injury:**  \_\_ \_\_/ \_\_ \_\_ / \_\_\_\_ \_\_ \_\_: \_\_ \_\_ : \_\_ \_\_  mm dd yyyy hh mm ss | | **Date of Consultation:** **Time of Consultation:**  \_\_ \_\_/ \_\_ \_\_ / \_\_\_\_ \_\_ \_\_: \_\_ \_\_ : \_\_ \_\_  mm dd yyyy hh mm ss | | **Place of Occurrence:**  Home Street  Other, specify:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Address of Occurrence: House No. & Street: Barangay: Municipality/City: Province:** | | | | |
| **Type of Involvement:**    Active Passive | | **Nature of Injury:**  Fireworks-related GSW-Straybullet Tetanus  Fireworks ingestion Unknown  Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **If fireworks related, type of injury:**  Blast/Burn WITH amputation  Blast/Burn NO amputation  Eye Injury  Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Diagnosis(to include nature and site):** | | |
| **Anatomical Location:** | | **Name of Firecracker:** | **Liquor Intoxication:**  Yes No | |
| **Treatment Given:**  ATS ATS/Toxoid  HTig HTig/Toxoid  Toxoid None  Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Disposition:**  Absconded Admitted  Discharged Home Against Medical Advise  Refuse Admission Transferred/Referred : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(transferred to/referred to)*  Treated and Sent Home Died    Other Disposition : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

|  |  |  |
| --- | --- | --- |
| **Prepared by:** | **Name:** | **Signature:** |
| **Noted by:** | **Name:** *(officer-of-the-day)* | **Signature:** |

**Annex 7.0 Violence Against Women and Children – Patient Information Sheet**

**DEPARTMENT OF HEALTH**

Draft VAWC Form: October 14, 2011

**Violence Against Women and Children**

**Patient Information Sheet**

**ER**   **OPD \_\_** New case \_\_ Revisit

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PATIENT DATA** | | | | |
| **Registry No.:** (Not to be filled in- computer generated) | | | **Hospital/Facility No.:** | |
| **Informant:**  Self (Patient/Victim)  Family member  Police  Others, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  None | | | | |
| **Patient’s Name: Last Name: First Name: Middle Name:** | | | | |
| **Address: House No. & Street: Barangay: Municipality/City: Province:** | | | | |
| **Sex:** Female Male  **Nationality: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Civil Status:**  Single Married  Live-in Widowed  Separate    **Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Date of Birth:**  \_\_ \_\_/ \_\_ \_\_ / \_\_\_\_  mm dd yyyy  **If Date of Birth is not available, Age in:**  Years \_\_\_\_\_\_  Months \_\_\_\_\_\_  Days \_\_\_\_\_\_ | | **Highest Educational Attainment:**  No formal education  College Level/Graduate  Elementary Level/Graduate  Post Graduate  High School Level/Graduate  Vocational  **Occupation:**  None/Unemployed  Unknown  Student  Others, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **INCIDENT INFORMATION** | | | | |
| **Case/Incident No.:**  **External referral from:**  DSWD DOJ NGO  NBI Relative Physician  PNP Neighbor Others, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Handling Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Address:**  **House No. & Street:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Barangay:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Municipality/City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Province:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date of Intake:** \_\_ \_\_/ \_\_ \_\_ / \_\_\_\_\_\_ (mm/dd/yyyy)  **Intake By:**  **Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Middle Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Designation/Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | RA 9262: Anti Violence against Women and Children Act Sexual Abuse Psychological Physical  Economic Others: \_\_\_\_\_\_\_\_\_\_\_\_\_  RA 8353: Anti – Rape Law of 1995  Rape by sexual intercourse Rape by sexual assault  RA 7877: Anti – Sexual Harassment Act  RA 7610: Special Protection of Children Against Child Abuse, Exploitation and Discrimination Act  Description of Incident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Place of Incident:**  Home Religious Institutions  Work Places of Medical Treatment  School Transport & Connecting Sites  Commercial Places Brothels and Similar Establishments  Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_ No response  **Geographic Location of Incident:**  **No. & Street:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Barangay:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Municipality/City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Province:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **Date of latest incident:**  \_\_ \_\_/ \_\_ \_\_ / \_\_\_\_\_\_\_\_  **mm dd yyyy**  **Time: \_\_\_\_\_\_\_\_\_\_\_\_**  **(military time to be entered)**  **Date of Consultation:**  \_\_ \_\_/ \_\_ \_\_ / \_\_\_\_\_\_\_\_  **mm dd yyyy**  **Time: \_\_\_\_\_\_\_\_\_\_\_\_**  **(military time to be entered)** | **Injury/ies Sustained:**  Abrasion  Avulsion  Burn  Concussion  Contusion  Fracture  Open Type Close Type  Open wound/ Laceration  Traumatic Amputation  Others, Specify :\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **HOSPITAL /FACILITY DATA:** | | | | |
| **Transferred from another hospital/facility**  Yes  No  **Referred by another Hospital /Facility for Laboratory**  and/or other medical procedures  Yes  No | | **Name of Originating Hospital/Physician** : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Status upon reaching Facility/Hospital**  Dead on Arrival Alive : If alive, please check if: \_\_\_ Conscious \_\_\_ Unconscious  **Mode of transport to the Hospital/Facility:**  Ambulance  Police vehicle  Private vehicle  Others, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Initial Impression: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **ICD-10 Code/s: Nature of Injury :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **ICD-10 Code/s: External cause of Injury:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Treatment Given :  Yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  **Outcome  Improved  Unimproved  Died**  **Disposition**  Admitted  Sent Home  Transferred to another facility/hospital, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  HAMA  Absconded | | | | |
| **B. IN-PATIENT (for admitted hospital cases only)** | | | | |
| **Complete Final Diagnosis:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Disposition**   Sent Home  Transferred  HAMA  Absconded  **Outcome**   Improved  Unimproved  Died  **ICD-10 Code/s: Nature of Injury :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **ICD-10 Code/s: External cause of Injury:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

|  |  |
| --- | --- |
| **PERPETRATOR INFORMATION** | |
| **PERPETRATOR** | |
| **Perpetrator’s Name: Last Name: First Name: Middle Name:** | |
| **Address: House No. & Street: Barangay: Municipality/City: Province:** | |
| **Sex:** Female Male **Age:**\_\_\_\_\_\_\_\_\_\_  **Nationality:** \_\_\_\_\_\_\_\_\_\_\_ **Religion:\_\_\_\_\_\_\_\_\_\_**  **Civil Status: Identifying Marks:**  Single Married \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Live-in Widowed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Separate  **Occupation:**  None/Unemployed  Unknown  Student  Others, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Relationship of the Perpetrator to victim:**  Current spouse/partner Former spouse/partner  Former fiancé/dating relationship Employer/manager/supervisor  Teacher/instructor/professor Coach/trainer  Neighbors/peers/coworkers/classmates Stranger  Current fiancé/dating relationship Agent of the employer  People of authority/service provider  Immediate family(e.g. father, mother \_\_\_\_\_\_\_\_\_\_\_\_\_)  Others relatives(e.g. uncle, cousin \_\_\_\_\_\_\_\_\_\_\_\_\_\_ )  Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **PERPETRATOR** | |
| **Perpetrator’s Name: Last Name: First Name: Middle Name:** | |
| **Address: House No. & Street: Barangay: Municipality/City: Province:** | |
| **Sex:** Female Male **Age:**\_\_\_\_\_\_\_\_\_\_  **Nationality:** \_\_\_\_\_\_\_\_\_\_\_ **Religion:\_\_\_\_\_\_\_\_\_\_**  **Civil Status: Identifying Marks:**  Single Married \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Live-in Widowed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Separate  **Occupation:**  None/Unemployed  Unknown  Student  Others, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Relationship of the Perpetrator to victim:**  Current spouse/partner Former spouse/partner  Former fiancé/dating relationship Employer/manager/supervisor  Teacher/instructor/professor Coach/trainer  Neighbors/peers/coworkers/classmates Stranger  Current fiancé/dating relationship Agent of the employer  People of authority/service provider  Immediate family(e.g. father, mother \_\_\_\_\_\_\_\_\_\_\_\_\_)  Others relatives(e.g. uncle, cousin \_\_\_\_\_\_\_\_\_\_\_\_\_\_ )  Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **PERPETRATOR** | |
| **Perpetrator’s Name: Last Name: First Name: Middle Name:** | |
| **Address: House No. & Street: Barangay: Municipality/City: Province:** | |
| **Sex:** Female Male **Age:**\_\_\_\_\_\_\_\_\_\_  **Nationality:** \_\_\_\_\_\_\_\_\_\_\_ **Religion:\_\_\_\_\_\_\_\_\_\_**  **Civil Status: Identifying Marks:**  Single Married \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Live-in Widowed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Separate  **Occupation:**  None/Unemployed  Unknown  Student  Others, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Relationship of the Perpetrator to victim:**  Current spouse/partner Former spouse/partner  Former fiancé/dating relationship Employer/manager/supervisor  Teacher/instructor/professor Coach/trainer  Neighbors/peers/coworkers/classmates Stranger  Current fiancé/dating relationship Agent of the employer  People of authority/service provider  Immediate family(e.g. father, mother \_\_\_\_\_\_\_\_\_\_\_\_\_)  Others relatives(e.g. uncle, cousin \_\_\_\_\_\_\_\_\_\_\_\_\_\_ )  Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **PERPETRATOR** | |
| **Perpetrator’s Name: Last Name: First Name: Middle Name:** | |
| **Address: House No. & Street: Barangay: Municipality/City: Province:** | |
| **Sex:** Female Male **Age:**\_\_\_\_\_\_\_\_\_\_  **Nationality:** \_\_\_\_\_\_\_\_\_\_\_ **Religion:\_\_\_\_\_\_\_\_\_\_**  **Civil Status: Identifying Marks:**  Single Married \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Live-in Widowed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Separate  **Occupation:**  None/Unemployed  Unknown  Student  Others, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Relationship of the Perpetrator to victim:**  Current spouse/partner Former spouse/partner  Former fiancé/dating relationship Employer/manager/supervisor  Teacher/instructor/professor Coach/trainer  Neighbors/peers/coworkers/classmates Stranger  Current fiancé/dating relationship Agent of the employer  People of authority/service provider  Immediate family(e.g. father, mother \_\_\_\_\_\_\_\_\_\_\_\_\_)  Others relatives(e.g. uncle, cousin \_\_\_\_\_\_\_\_\_\_\_\_\_\_ )  Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

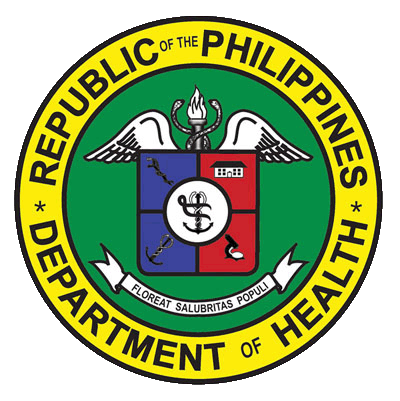
\*Use another Perpetrator Information sheet if needed.

**Annex 8.0 Persons with Disability Registration Form**

**D e p a r t m e n t o f H e a l t h**

San Lazaro Compound, Sta. Cruz, Manila

Republic of the Philippines

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **P h i l i p p i n e R e g i s t r y F o r m**  **f o r P e r s o n s w i t h D i s a b i l i t y** | | | | | | | | | | | | | | | | | *Place*  *1” x 1”*  *Photo*  *here* |
| **REGISTRATION NUMBER:** | | |  | | | | | | **DATE:** |  | | | | | | |
| **LAST NAME:** | | | | | **FIRST NAME:** | | | | | | | | **MIDDLE NAME:** | | | | |
|  | | | | |  | | | | | | | |  | | | | |
| **TYPE OF DISABILITY *(Please check only one)*:** | | | | | | | | | | | | | | | | | |
| Psychosocial Disability Chronic Illness with Disability Learning Disability  Mental Disability Visual Disability Orthopedic (Musculoskeletal) Disability  Hearing Disability Speech Impairment Multiple Disabilities | | | | | | | | | | | | | | | | | |
| **ADDRESS:** | | | | | | | | | | | | | | | | | |
| **House No. and Street** | | | | **Barangay** | | | | **Municipality** | | | | | **Province** | | | **Region** | |
|  | | | |  | | | |  | | | | |  | | |  | |
| **TEL. NOS.:** |  | | | **MOBILE NO.:** | |  | | | | | | **EMAIL ADDRESS:** | | |  | | |
| **DATE OF BIRTH *(mm/dd/yyyy)*:** | | | | **SEX *(Please check one)*:** | | | | | | | | **BLOOD TYPE:** | | | | | |
|  | | | | Male Female | | | | | | | |  | | | | | |
| **CIVIL STATUS *(Please check one)*:** | | | | | | | | | | | | | | | | | |
| Single Married Widow/er Separated Live-in | | | | | | | | | | | | | | | | | |
| **EDUCATIONAL ATTAINMENT *(Please check one)*:** | | | | | | | | | | | | | | | | | |
| Elementary Elementary Undergraduate High School  High School Undergraduate College College Undergraduate  Graduate Post Graduate Vocational None | | | | | | | | | | | | | | | | | |
| **EMPLOYMENT STATUS *(Please check one)*:** | | | | | | | | | | | | | | | | | |
| Employed Unemployed Displaced Worker  Resigned Retired Returning Overseas Filipino Worker | | | | | | | | | | | | | | | | | |
| **NATURE OF EMPLOYER *(Please check one if employed)*:** | | | | | | | | | | | | | | | | | |
| Private Government | | | | | | | | | | | | | | | | | |
| **TYPE OF EMPLOYMENT *(Please check one if employed)*:** | | | | | | | | | | | | | | | | | |
| Contractual Permanent Self-Employed Seasonal | | | | | | | | | | | | | | | | | |
| **OCCUPATION *(Please check one)*:** | | | | | | |  | | | | | | | | | | |
| Officials of Government and Special Interest  Organizations, Corporate Executives, Managers,  Managing Proprietors and Supervisors  Professionals  Technicians and Associate Professionals  Clerks  Service Workers and Shop and Market Sales  Workers  Farmers, Forestry Workers and Fisherman  Trades and Related Workers  Plant and Machine Operators and Assemblers  Laborers  Unskilled Workers  Special Occupation  Not Applicable | | | | | | | **SSS No.:** | | | |  | | | | | | |
| **GSIS No.:** | | | |  | | | | | | |
| **Philhealth No.:** | | | |  | | | | | | |
| Philhealth Member  Philhealth Member Dependent | | | | | | | | | | |
| **ORGANIZATIONAL INFORMATION:** | | | | | | | | | | |
| Organization Affiliated: | | | |  | | | | | | |
| Contact Person: | | | |  | | | | | | |
| Office Address: | | | |  | | | | | | |
| Tel. Nos.: | | | |  | | | | | | |
|  | | **Last Name** | | | | | **First Name** | | | | | | | **Middle Name** | | | |
| **FATHER’S NAME:** | |  | | | | |  | | | | | | |  | | | |
| **MOTHER’S NAME:** | |  | | | | |  | | | | | | |  | | | |
| **GUARDIAN’S NAME:** | |  | | | | |  | | | | | | |  | | | |
| **ACCOMPLISHED BY:** | |  | | | | |  | | | | | | |  | | | |
| **NAME OF REPORTING UNIT:** | |  | | | | | | | | | | | | | | | |

**Annex 9.0 Incident Report**

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**Incident Report Form**

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| --- | --- | --- | --- |
| **Name of Hospital** |  | | |
| **Address** |  | | |
| **Date of Report** |  | **Time of Report** |  |
| **Name of Requesting Party** |  | | |
| **Position** |  | | |
| **Signature** |  | | |
| **Remarks** |  | | |

|  |  |  |
| --- | --- | --- |
| **Approved By:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name and Signature of Chief/Director of Hospital | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date |
| **Approved for Editing:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name and Signature of DOH Personnel | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date |
| **Edited By:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name and Signature of Editing Personnel | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date |