Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

FEB 07 2013

ADMINISTRATIVE ORDER
NO. 2013 - 0005

SUBJECT: **National Policy on the Unified Registry Systems of the Department of Health (Chronic Non-Communicable Diseases, Injury Related Cases, Persons with Disabilities, and Violence Against Women and Children Registry System)**

I. 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.

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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.

II. 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 II***, 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. ***Administrative Order No. 2007-0010,*** National Policy on Violence and Injury Prevention
6. ***Administrative Order No. 16-A, s. 1999*** Guidelines on the Issuance of Certification of Disability to Persons with Disabilities
7. ***Administrative Order No. 1-B, s. 1997,*** Establishment of a Women and Children Protection Unit in All DOH Hospitals
8. ***Administrative Order No. 16-A s. 1995*** on Diabetes Mellitus Prevention and Control Program in the Philippines.
9. ***Administrative Order No. 89-A s. 1990, amendment to A.O. No. 188-A s. 1973*** on the Philippine National Cancer Control Program
10. ***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
11. ***Administrative Order No. 188-A s. 1973,*** Authority and Functions of the National Cancer Control Center of the DOH
12. ***Department Memorandum No. 2008-0204*** on Collection and Submission of Philippine Renal Disease Registry Forms.

III. 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.

IV. 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.

V. DEFINITION OF TERMS

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

1.	BHFS	Bureau of Health Facilities and Services
2.	CHD	Center for Health Development
3.	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.All rights reserved. http://medical-dictionary.thefreedictionary.com/clinical+diagnosis)
4.	COPD	Chronic Obstructive Pulmonary Diseases
5.	DOH	Department of Health
6.	ICNCDRS	Integrated Chronic Non-Communicable Disease Registry
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)
8.	IMS	Information Management Service
9.	NCDPC	National Center for Disease Prevention and Control
10.	NCHFD	National Center for Health Facility Development
11.	NEC	National Epidemiology Center
12.	Medical Associations	Refer to associations like Medical Societies, Specialty Divisions and Specialty Societies, Affiliate Societies, and other related associations.
13.	Reportable Case	Refers to diagnosed or confirmed chronic non-communicable disease, injury, violence, or disability.
14.	Reporting Health Facilities	Refer to government and private clinics, hospitals, medical societies and other professional organizations with existing information systems.
15.	URS (Unified Registry Systems)	Collection of data related to patients with diagnosed/confirmed cases on chronic non-communicable diseases, injuries, violence, and disabilities.

VI. GENERAL GUIDELINES

1. The Unified Registry Systems shall 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.
2. Professional societies and those with existing information systems shall upload the required data to the DOH Information Management Service to generate national data.
3. The security, confidentiality, and integrity of data shall at all times be secured and/or protected.
4. 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.

VII. SPECIFIC GUIDELINES

A. Unified Registry Systems' Reporting

The Unified Registry Systems shall 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.

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.

1. Reporting health facilities refer to government and private clinics and hospitals. All reporting health 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 to the URS.

2. Regular basis shall refer to the frequency of reporting, namely:

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

3. 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:

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

4. 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.

5. For Chronic Non-Communicable Disease and Persons with Disability monthly reporting, the period for entering or uploading data shall be *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.*

6. 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.

7. 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.

B. 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 IMS 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.

C. Security of Data

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 shall undergo the following processes to request for editing:

    i. Fill up the Incident Report (Annex 9.0) with the approval signature of the head of the reporting health facility or duly authorized personnel.
    ii. Submit the Incident Report to the NCDPC via personal delivery or mail.
    iii. 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:

    i. Objectives of the national public health programs including public health safety and benefits
    ii. Use of the data
    iii. Identity of the officers or persons to whom the data will be given or disclosed
    iv. 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.

D. 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:

   i. Non-compliance in reporting data
   ii. Irregular reporting of data
   iii. Delayed reporting of data
   iv. With deficiency findings as validated or assessed by the NCDPC, NEC, and/or IMS.
   v. With verbal or written complaints reported or filed by concerned offices, individuals, or other organizations.
   vi. Other factors that may identified during system implementation.

3. 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.

E. 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."

VIII. ROLES AND RESPONSIBILITIES

1. Reporting Health Facilities (Government Hospitals, Private Hospitals and Clinics and Professional Societies with existing registry) shall:

a. Designate full time and backup personnel who shall be responsible for entering or uploading data into the systems.
b. Enter or upload quality data, i.e. accurate, valid, reliable, and/or timely on a regular basis.
c. Report erroneous submitted data to the NCDPC for proper correction or editing.
d. Report problems that are encountered during operations through the online reporting system.

2. National Center for Disease Prevention and Control shall:

a. Manage the overall implementation of the registry system including direction and guidance in the continuing operations, system enhancement, and data management.
b. Formulate processes, procedures, policies and guidelines related to the registry system.
c. Address issues, concerns, and/or problems accordingly like respond to queries about the forms, reports and standard operating procedures or processes.
d. Formulate policies, procedures, guidelines, and relevant protocols to ensure continuous operations, and develops program interventions as needed.
e. Validate data according to agreed level of validation to confirm its quality.

f. Review management, statistical, and other reports with the end objective of providing the necessary recommendations or comments.
g. Compile and publish reports on non-communicable diseases data.
h. Provide funds to support studies/researches as a result of data findings.
i. In collaboration with the concerned specialty societies shall analyze and interpret the data generated from the system.
j. Suspend, terminate or lift the user accounts if reporting facilities failed to comply with the reporting standards and/or divulged any form information without any prior authorization from the DOH.
k. Issue a Memorandum of Agreement between the DOH and those facilities with existing information systems for systematic data uploading, confirmation of roles, duties and responsibilities, and commitment to upload the data.

3. National Epidemiology Center shall:

a. Support the development of processes, procedures, policies and guidelines related to the registry system.
b. Address issues, concerns, and/or problems accordingly.
c. Assist in the formulation of policies, procedures, guidelines, and relevant protocols to ensure continuous operations, and develops program interventions as needed.
d. Review management, statistical, and other reports with the end objective of providing the necessary recommendations or comments.
e. Validate data according to agreed level of validation to confirm its quality.
f. Provide funds to support studies/researches as a result of data findings.
g. Monitor the implementation of the system.
h. Supervise data management.

4. Information Management Service shall:

a. Maintain the registry software.
b. Address technical problems accordingly.
c. Train users on how to operate the registry system.
d. Assist in the formulation of policies, procedures, guidelines, and relevant protocols to ensure continuous operations, and develops program interventions as needed.
e. Perform database and network management activities.
f. Manage the help desk support to ensure continuous operations.
g. Provide funding on information and communication technology resources based on the DOH Information System Strategic Plan or other DOH directives or issuances.

5. National Center for Health Promotion shall:

a. Translate the salient findings into messages and materials that are appropriate for specific population segments.
b. Conduct communication activities through various media channels to elicit public opinion and generate public discussion favorable to disease prevention and control.

6. National Center for Health Facility Development shall:

a. Provide implementation support like developing guidelines and policies to ensure continuous compliance of hospitals to this directive.
b. Monitor the implementation of the system operation.

7. Bureau of Health Facilities and Services shall:

a. Provide implementation support like developing guidelines and policies to ensure continuous compliance of hospitals to this directive.
b. Monitor the implementation of the system operation.

8. **Center for Health Development shall:**

   a. Ensure timely entry or uploading of quality data into the registry system.
   b. Report erroneous data for correction or editing using the Incident Report Form.
   c. Report problems that are encountered during operations.
   d. Participate in the evaluation of the registry system to further improve the functionalities or performance of the system.
   e. Provide technical assistance such as training and monitoring activities and lead the regions to ensure the implementation of all the systems.

9. **Local Government Units (Provincial Health Office, District Health Office and Municipal Health Office) shall:**

   a. Provide implementation support to ensure continuous compliance of to this directive.
   b. Ensure availability of all data collection, processing, monitoring and reporting forms or tools in each reporting facility.
   c. Provide technical assistance such as training and monitoring activities to ensure the implementation of all the systems.

10. **Professional Societies (Medical, Nursing, and other Paramedical Societies), Development Partners and Private Organizations**

   a. Professional societies with existing information systems shall upload the required data to the DOH Information Management Service to generate national data.
   b. Shall provide expert inputs on the analysis and interpretation of the data gathered from the registries.
   c. Shall participate in the evaluation of the registry system to further improve the functionalities or performance of the system.

IX. REPEALING CLAUSE

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

X. SEPARABILITY

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

XI. EFFECTIVITY

This order shall be effective immediately.

ENRIQUE T. ONA, MD, FPCS, FACS
Secretary of Health

DEPARTMENT OF HEALTH
Integrated Chronic Non-Communicable Disease Registry System

Annex 1.0

Cancer Registry Form

1 National Registry No.

Note: Please put N/A for Not Applicable fields. Kindly refer to the instruction on how to fill up the form at the back.

GENERAL DATA

2 Name of Reporting Health Facility	*3 Hospital Patient ID No.	*4 Hospital Registry No.	*5 Hospital Case No.	*6 Type of Patient O OPD O In Patient

*7 Name of Patient	*8 Sex	*9 Civil Status
Last Name _____ First Name _____ Middle Name _____	O Female O Male	O Single O Married O Widow/er O Separated O Co-Habitation ☐ Annulled ☐ Divorced

*10 **Mother's Maiden Name** _____ Last Name _____ First Name _____ Middle Name

*11 Permanent Address	12 Landline #
Number & Street Name _____ Region _____ Province _____ City/Municipality _____ Barangay _____ Zip Code _____	12a Mobile #
11a Temporary Address	12b Email Address
Number & Street Name _____ Region _____ Province _____ City/Municipality _____ Barangay _____ Zip Code _____	

13 Birth Date	14 If Date of Birth is not available	*15 Place of Birth (Province,City/Municipality)	*16 Religion	18 Race
___/___/____ mm dd yyyy	____Yrs ____ Mos ____ Days		*17 Nationality	19 Ethnicity

*20 Highest Educational Attainment	*21 Occupation	22 Company	23 PhilHealth #	23a Common Reference #

24 Contact Person (in case of emergency) _____ Last Name _____ First Name _____ Middle Name	24 Landline #	24 Email Address
24 Address Number & Street Name _____ Region _____ Province _____ City/Municipality _____ Barangay _____ Zip Code _____	24 Mobile #	
24a Contact Person (in case of emergency) _____ Last Name _____ First Name _____ Middle Name	24a Landline #	24a Email Address
24a Address Number & Street Name _____ Region _____ Province _____ City/Municipality _____ Barangay _____ Zip Code _____	24a Mobile #	
24b Contact Person (in case of emergency) _____ Last Name _____ First Name _____ Middle Name	24b Landline #	24b Email Address
24b Address Number & Street Name _____ Region _____ Province _____ City/Municipality _____ Barangay _____ Zip Code _____	24b Mobile #	

PATIENT HISTORY

*25 O **Smoking**
O Less than/Equal to 1 pack consumed per day
O More than 1 pack consumed/day

Age started Smoking: _____
No. of Years Smoking: _____

*25a O **Second Hand Smoke (SHS)**
O With Exposure to SHS
Number of Years: _____

*25b O **Occupational Exposure**
☐Cement Dust ☐Cotton
☐Grains ☐Metal
☐Paper Mill ☐Silica
☐Others, specify
_____

*25c O **Indoor Air Pollution**
Type of Indoor Air Pollutant
_____

*25d O **Outdoor Air Pollution**
Type of Outdoor Air Pollutant
_____

*26 O **Physical Activity**
a.Type: _____
_____
_____
b. Minutes per Exercise Activity:
_____
_____
c. Frequency O Daily O Weekly O Monthly O Yearly O Quarterly

*27 O **Usual/ Typical Diet Intake**
O **Fish, Meat, Poultry, Egg**
Specify _____
Frequency O Daily O Weekly O Monthly O Yearly O Quarterly
O **Rice, Grains, Bread, Cereals, RootCrops**
Specify _____
Frequency O Daily O Weekly O Monthly O Yearly O Quarterly
O **Fruits/Vegetables**
Specify _____
Frequency O Daily O Weekly O Monthly O Yearly O Quarterly
O **Fats, Oils**
Specify _____
Frequency O Daily O Weekly O Monthly O Yearly O Quarterly
O **Sugar, Sweet**
Specify _____
Frequency O Daily O Weekly O Monthly O Yearly O Quarterly
O **Milk and Milk Products**

27a O **Regularity of Bowel Movement**
O Once a day O Others, _____
O Twice a day

*28 O **Drinking of Alcoholic Beverage**
a. Type: _____
b. Amount: _____
c. Unit of Measure: O Bottle O Glass O Shot
d. Frequency: O Daily O Weekly O Monthly O Yearly O Quarterly
Age started drinking alcohol: _____
No. of Years drinking alcohol: _____

29 **Number of sexual partners** _____

*30 O **Early Age of Sexual Intercourse** _____

*32 O **Chemical Exposure**
Type/s of Chemical: _____
Length of Exposure: _____

*33 O **Family History/Cancer**

Family Member	Type of Cancer

*34 **Height in Meter**

*34a **Weight in Kilograms**

*35 **Body Mass Index**

DEPARTMENT OF HEALTH
Integrated Chronic Non-Communicable Disease Registry System

Annex 1.0

Specify _____ FrequencyODaily OWeekly OMonthly OYearly OQuarterly O **Others** Specify _____ FrequencyODaily OWeekly OMonthly OYearly OQuarterly	*31 O **Use of contraceptive, specify** _____ **No. of years used:** _____	*35a **Classification (BMI)** *36 **Waist circumference in centimeters** *36a **Classification (WC)**

*37 **Infections (if applicable)**
aO Human Papilloma Virus Infection Year Examined/Dx: _____ cO Hepatitis B Virus Infection Year Examined/Dx: _____
bO Helicobacter Pylori Infection Year Examined/Dx: _____ dO Others, specify _____ Year Examined/Dx: _____

CANCER DATA

*38 O**Referred From**	39 **Name of Referring Health Facility/Doctor/Health Care Professional**	40 **Reason for Referral**
*41 **Date of Consultation/ Admission** ___/___/____ mm dd yyyy	*42 **Chief Complaint:**	*43 **Date of Diagnosis** ___/___/____ mm dd yyyy

*44 **Most Valid Basis of Diagnosis**
O **Non-Microscopic:** ☐Death Certificates Only ☐Clinical Investigation ☐Clinical Only ☐Specific Tumor Markers
O **Microscopic** : ☐Cytology or Hematology ☐Histology of Metastasis ☐Histology of Primary
O **Unknown**

45 **Multiple Primaries**
O1
O2
O3

*46 **Primary Sites** →
☐Colon ☐Brain ☐Bladder ☐Thyroid ☐Uterine Cervix
☐Liver ☐Corpus Uteri ☐ Urinary ☐ Gall ☐Breast ☐Blood
☐Ovary ☐Lung ☐Esophagus ☐Kidney ☐Oral Cavity
☐Stomach ☐Pancreas ☐Skin ☐Nasopharynx
☐Testis ☐Prostate ☐Rectum
☐Others, specify _____

*47 **Laterality:** OLeft ORight OBilateral OMid ONot Stated	48 **Histology (Morphology)**	49 **TNM System** **T**_____**N**_____**M**_____

*50 **Staging** OIn-Situ OLocalized ODirect Extension ORegional Lymph Node O3+4 ODistant Metastasis OUnknown

*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-10 Code**

*54 **Treatment Purpose** ☐Curative-complete ☐ Curative-incomplete ☐Palliative only
☐Others, specify _____

*54a **Primary Treatment given in this Hospital** _____ **Date** ___/___/____ mm dd yyyy
_____

54b **Planned Additional/Adjuvant Treatment/s actually received in this Hospital** ☐Surgery ☐Radiotherapy ☐Chemotherapy ☐Immunotherapy/Cryotherapy ☐Hormonal ☐Unknown ☐Others, specify _____

54c **Additional/Adjuvant Treatment/s** ☐Surgery ☐Radiotherapy ☐Chemotherapy ☐Immunotherapy/Cryotherapy ☐Hormonal ☐Unknown ☐Others, specify _____

54d **Treatment/s received in other Hospital** ☐Surgery ☐Radiotherapy ☐Chemotherapy ☐Immunotherapy/Cryotherapy ☐Hormonal ☐Unknown ☐Others, specify _____

*55 **Patient Status** O Recovered O Improved O Unimproved O Died

56 **If died, underlying Cause of Death**	57 **If died, underlying Cause of Death: ICD-10 Code**	
58 **Date of Death** ___/___/____ (mm/ dd/ yyyy)	59 **Place of Death**	*60 **Disposition** O Admitted O Discharge Against Medical Advice O Discharged O Treated and Sent Home O Transferred O Absconded
61 **If Transferred, Name of Health Facility**	62 **Reason for Referral**	

63 **Consultant in-charge** _____, _____, _____ _____ Last Name First Name Middle Name Department	63b **Landline #**	63d **Email Address**
63a **Address** _____ _____ _____ _____ _____ _____ Number & Street Name Region Province City/Municipality Barangay Zip Code	63c **Mobile #**	
*64 **Completed By** _____, _____, _____ _____ Last Name First Name Middle Name Designation	64b **Landline #**	64d **Email Address**
64a **Address** _____ _____ _____ _____ _____ _____ Number & Street Name Region Province City/Municipality Barangay Zip Code	64c **Mobile #**	*65 **Date Completed** ___/___/___ mm dd yyyy

DEPARTMENT OF HEALTH
Integrated Chronic Non-Communicable Disease Registry System

Input Instruction Form

Field No.	Field Name	Instruction
1.	National Registry No.	Do not fill up. It is a system generated number to uniquely identify each record or data entered into the national registry.
2.	Name of Reporting Health Facility	Write the name of the Hospital, Center or Clinic who is submitting the report.
3.	Hospital Patient I.D. No.	Write the hospital-based issued I.D. or number to uniquely identify the patient.
4.	Hospital Registry No.	Write the hospital-based issued I.D. or number to uniquely identify the patient.
5.	Hospital Case No.	Write the hospital-based issued number to uniquely identify each case or incidence.
6	Type of Patient	Check the button for the corresponding type of patient the victim is.
7.	Name of Patient: Last Name, First Name, Middle Name	Write the patient's Last name, First name and Middle name in the appropriate spaces provided. ***Note: None may be written if no informant can provide the information.***
8.	Sex	Check the appropriate box for the sex of the injured by birth.
9.	Civil Status	Check the appropriate box for the civil status of the injured. Not legally separated still to be considered as "Married"
10.	Mother's Maiden Name	Write the mother's name of the patient before marriage. The full middle name must be entered. If there is no middle name, write"N/A".
11.	Permanent Address	Write the patient's permanent address - House No. and Street, Barangay, Municipality/City and Province
11a.	Temporary Address	Write the patient's temporary address - House No. and Street, Barangay, Municipality/City and Province
12,12a, 12b	Landline #, Mobile #, Email Address	Write the patient's contact details such as landline number, mobile number and email address.
13.	Birth Date	Write the date of birth of the patient in the format mm/dd/yyyy (eg. July 1, 1970 should be entered as 07/01/1970)
14.	If Date of Birth is not available (Yrs/Mos/Days)	If date of birth cannot be provided then enter in the space provided the age of the patient in years or months or days.
15.	Place of Birth	Write the Province and the City/Municipality where the patient was born.
16.	Religion	Write the patient's religion
17.	Nationality	Write the patient's nationality
18.	Race	Write the race of the person which describes the skin color, i.e. American (Red Skin), Caucasian (White Skin), Ethiopian (Black Skin), Malay (Brown Skin), Mongolian (Yellow Skin)
19.	Ethnicity	Write the ethnicity of the patient, e.g. Asian, Indian, Pacific Islander, or others
20.	Highest Educational Attainment	Write the highest educational attainment of the patient whether he is elementary, high school, vocational, college, post graduate, or others.
21.	Occupation	Check the appropriate box for the occupation of the injured.
22.	Company	Write the name of the company where the injured is working.
23.	PhilHealth	Write the PhilHealth Number if member or dependent.
24.	Common Reference #	Write the Unified Multi-Purpose ID Common Reference No. if the patient has any. **(UMID CRN can be found in the upgraded, present government IDs such as the SSS, GSIS and Philippine Health Insurance Corp. UMID-CRN is the primary identifier of an individual transacting business or availing of services from any government agency.)**
24 24a-24d	Contact Person (in case of emergency) , Address, Landline #, Mobile #, Email Address	Write the name of the person that may be contacted should any emergency may happen to the patient. Write the address and other contact details such as landline number, mobile number and the email address.
25.	Smoking	Check the button if the patient is smoking cigarettes and how much the patient is consuming per day. Write the age the patient started smoking and the number of years the patient has been smoking.
25a.	Second Hand Smoke	Check the button if the patient is exposed to second hand smoke, write the number of years the patient has been exposed to second hand smoking.
25b.	Occupational Exposure	Check if the patient has been exposed to any kind of material in relation to the patient's occupation.
25c.	Indoor Air Pollution	Check the button if the patient has been exposed to Indoor Air Pollution. Write the type of Indoor Air Pollutant.
25d.	Outdoor Air Pollution	Check the button if the patient has been exposed to Outdoor Air Pollution. Write the type of Outdoor Air Pollutant.
26.	Physical Activity	Check the button if the patient is undergoing physical activity. Write the type of activities and the frequency each activity is being undertaken by the patient.
27.	Diet Intake	Check and specify the details of the patient's usual/typical diet.
27a.	Regularity of Bowel Movement	Check how frequent is the bowel movement of the patient.
28.	Drinking of Alcoholic Beverage	Check the button if the patient is drinking alcohol or beverage. Write the type of alcoholic beverage, amount consumed, unit of measure and frequency, i.e. daily, weekly or monthly per consumption. Write the age the patient started drinking alcohol and the number of years the patient has been drinking.
29.	Number of sexual partners	Write the number of sexual partners the patient had.
30.	Early Age of Sexual Intercourse	Check the button for the history of early age of sexual intercourse; write the age when the patient had her first sexual intercourse.
31.	Use of contraceptive	Check the button if the patient uses contraceptives. Write the type of contraceptive the patient has been using and the number of years the patient has been using the contraceptive.
32.	Chemical Exposure, specify	Check the button if the patient has been exposed to any form of chemical. Write the kind of chemical the patient has been exposed to and the length of the exposure.
33.	Family History/ Cancer	Check the button for the family history of cancer. Write the family member who has suffered cancer and the type of cancer the family member has or had.
34.	Height in Meter	Write the patient's Height in Meter
34a.	Weight in Kilograms	Write the patient's Weight in Kilograms
35.	Body Mass Index	Compute for the BMI with the given formula BMI = (Weight in Kilograms / (Height in Meters x Height in Meters)) Then write the computed Body Mass Index
35a.	Classification (BMI)	Computation of Classification-BMI: Underweight < 18.5 Normal 18.6 – 22.9 Overweight > 23.0 At risk 23.0 – 24.9 Obese I 25.0 – 29.9 Obese II > 30.0
36.	Waist Circumference in Centimeters	Write the waist circumference in centimeters.

36a.	Classification (WC)	Waist Circumference are classified into: Not At Risk (Male: < 90); At Risk (Male: > 90) Not At Risk (Female: < 80); At Risk (Female: > 80)
37.	Infections	Check the button for the type of virus infection the patient has been infected with: a. Human Papilloma Virus Infection and write year examined/Dx b. Helicobacter Pylori Infection and write year examined/Dx c. Hepatitis B Virus Infection and write year examined/Dx d. Others Virus Infection and write year examined/Dx
38.	Referred From	Check the button if the patient came from other hospital or clinic, and was referred to the hospital.
39.	Name of Referring Health Facility	Write the name of the hospital or clinic where the patient came from.
40.	Reason for Referral	Write the reason why the patient was referred to the hospital.
41.	Date of Consultation/Admission	Write the date when the patient first came to the hospital in mm/dd/yyyy format.
42.	Chief Complaint	Write the symptoms or signs of illness or dysfunction that caused the patient to seek medical help.
43.	Date of Diagnosis	Write the date when the patient was diagnosed with any type or kind of cancer using mm/dd/yyyy format.
44.	Most valid basis of diagnosis	Check the button of the basis of diagnosis of a cancer. For non-microscopic, microscopic and unknown.
45.	Multiple Primaries	Write if there are two or more abnormal growths of tissue occurring simultaneously.
46.	Primary site	Check the button where the location of the complaints where felt or exhibited.
47.	Laterality	Check the button where the complaints where felt or exhibited based on the primary site (topography).
48.	Histology	Write the microscopic report on the tumor biopsy of the patient.
49.	TNM System	Write the extent of cancer of the patient. Where T describes the size of the tumor, N describes regional lymph nodes involved, M describes distant metastasis.
50.	Staging	Check the button if what stage of cancer the patient is diagnosed with.
51.	Sites of Distant Metastasis	Check the box where the cancer has spread.
52.	Final Diagnosis	Write the patient's final diagnosis.
53.	Final Diagnosis (ICD10-Code)	Write the corresponding ICD10 code for the patient's final diagnosis.
54.	Treatment Purpose	Check the purpose of the treatment given to the patient.
54a.	Primary Treatment given in this Hospital	Write the primary treatment given by the hospital to the patient. Write the date when the treatment was administered.
54b.	Planned Additional/Adjuvant Treatment/s actually received in this Hospital	Check the corresponding box for the Planned Additional/Adjuvant Treatment/s actually received by the in the Hospital
54c.	Additional/Adjuvant Treatment/s	Check the corresponding box for the Additional/Adjuvant Treatment/s needed by the patient if there's any.
54d.	Treatment/s received in other Hospital	Check the corresponding box for the Treatment/s received in other hospital by the patient if there's any.
55.	Patient Status	Check the Patient Status whether recovered, improved and unimproved upon discharge.
56.	If Died, underlying cause of death	Write the fundamental cause of death of the patient.
57.	If Died, underlying cause of death, ICD-10 CODE	Write the ICD-10 code for the fundamental cause of death of the patient.
58.	Date of Death	Write the date when the patient died using mm/dd/yyyy format.
59.	Place of Death	Write the province and city/municipality where the patient died.
60.	Final Disposition	Write whether the patient was admitted, discharged, transferred, Discharge against medical advice, treated and sent home, absconded and died.
61.	If transferred, Name of Health Facility	Write the name of the Health Facility where the patient was transferred.
62.	Reason for Referral	Write the reason why the Patient was transferred to another Health facility.
63. 63a. 63b. 63c. 63d.	Consultant in-charge Address Landline # Mobile # Email Address	The position title /designation of the Consultant in-charge must be entered on this portion including the address and contact details (landline no., mobile no. and email address).
64. 64a. 64b. 64c. 64d.	Completed By Address Landline # Mobile # Email Address	The position title /designation of the personnel completing the form must be entered on this portion including the address and contact details (landline no., mobile no. and email address). The name and signature of the personnel completing the form must be entered on this portion.
65.	Date Completed	Write the Date of registry was completed and encoded using the mm/dd/yyyy format.

DEPARTMENT OF HEALTH
Integrated Chronic Non-Communicable Disease Registry System

Annex 2.0

Chronic Obstructive Pulmonary Disease Registry Form

Note: Please put N/A for Not Applicable fields. Kindly refer to the instruction on how to fill up the form at the back.

1 National Registry No.

GENERAL DATA

2 **Name of Reporting Health Facility**	3 **Hospital Patient ID No.**	4 **Hospital Registry No.**	5 **Hospital Case No.**	6 **Type of Patient** O OPD O In Patient

7 **Name of Patient**
Last Name _____ First Name _____ Middle Name _____

8 **Sex**
O Female
O Male

9 **Civil Status**
O Single O Married
O Widow/er O Separated
O Co-Habitation ☐ Annulled ☐ Divorced

10 **Mother's Maiden Name** Last Name _____ First Name _____ Middle Name _____

11 **Permanent Address**
Number & Street Name _____ Region _____ Province _____ City/Municipality _____ Barangay _____ Zip Code _____

12 **Landline #**

12a **Mobile #**

11a **Temporary Address**
Number & Street Name _____ Region _____ Province _____ City/Municipality _____ Barangay _____ Zip Code _____

12b **Email Address**

13 **Birth Date**	14 **If Date of Birth is not available**	15 **Place of Birth** (Province,City/Municipality)	16 **Religion**	18 **Race**
___/___/___ mm dd yyyy	___Yrs ___ Mos ___ Days		17 **Nationality**	19 **Ethnicity**

20 **Highest Educational Attainment**	21 **Occupation**	22 **Company**	23 **PhilHealth #**	23a **Common Reference #**

24 **Contact Person** (in case of emergency) Last Name _____ First Name _____ Middle Name _____

24b **Landline #**

24d **Email Address**

24a **Address**
Number & Street Name _____ Region _____ Province _____ City/Municipality _____ Barangay _____ Zip Code _____

24c **Mobile #**

PATIENT HISTORY

25 O **Smoking**
O Less than/Equal to 1 pack consumed per day
O More than 1 pack consumed/day

Age started Smoking: _____
Number of Years Smoking: _____

26 O **Second Hand Smoke (SHS)**
O With Exposure to SHS
Number of Years: _____

27 O **Occupational Exposure**
☐Cement Dust
☐Cotton
☐Grains
☐Metal
☐Paper Mill
☐Silica
☐Others, specify _____

28 O **Pulmonary Infections**
☐TB
☐Others, specify _____

29 O **Indoor Air Pollution**
Type of Indoor Air Pollutant
_____

30 O **Outdoor Air Pollution**
Type of Outdoor Air Pollutant
_____

COPD DATA

31 **Type of COPD, specify** _____

32 O**Referred From**	33 **Name of Referring Health Facility**	34 **Reason for Referral**

35 **Date of Consultation/Admission** ___/___/___ mm dd yyyy

36 **Date of Diagnos** ___/___/___ mm dd yyyy

37 **Sign/Symptoms** → ☐Chest Tightness ☐Chronic Cough ☐Clubbing of the Fingers ☐Cyanosis ☐Dyspnea ☐Frequent Chest Infections ☐ Hemoptysis ☐Increase in Sputum Production ☐Wheezing ☐Others, specify_____

38 **Treatment** → ☐Bronchodilator ☐Corticosteroids ☐Combination Corticosceroids – long Acting Beta 2-agonis ☐Mucolytics ☐Antibiotics ☐Others, specify _____

39 **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

40 **Final Diagnosis: POST BRONCHODILATOR FEV/FVC < 70%** _____**(Spirometry)**

41 **Final Diagnosis: ICD-10 Code**

42 **Patient Status** O Recovered O Improved O Unimproved O Died

43 ***If died, underlying Cause of Death***	44 **If died, underlying Cause of Death: ICD-10 Code**

45 **Date of Death** ____/____/____ (mm/ dd/ yyyy)	46 **Place of Death**	47 **Disposition** O Admitted O Discharged O Transferred O Discharge Against Medical Advice O Treated and Sent Home O Absconded
48 **If Transferred, Name of Health Facility**		49 **Reason for Referral**

50 **Consultant in-charge** _____, _____, _____ _____ (Last Name, First Name, Middle Name, Department)	50b **Landline #**	50d **Email Address**
50a **Address** _____ _____ _____ _____ _____ _____ (Number & Street Name, Region, Province, City/Municipality, Barangay, Zip Code)	50c **Mobile #**	
51 **Completed By** _____, _____, _____ _____ (Last Name, First Name, Middle Name, Designation)	51b **Landline #**	51d **Email Address**
51a **Address** _____ _____ _____ _____ _____ _____ (Number & Street Name, Region, Province, City/Municipality, Barangay, Zip Code)	51c **Mobile #**	52 **Date Completed** ____/____/____ mm dd yyyy

Input Instruction Form

Field No.	Field Name	Instruction
1.	National Registry No.	Do not fill up. It is a system generated number to uniquely identify each record or data entered into the national registry.
2.	Name of Reporting Health Facility	Write the name of the Hospital, Center or Clinic who is submitting the report.
3.	Hospital Patient I.D. No.	Write the hospital-based issued I.D. or number to uniquely identify the patient.
4.	Hospital Registry No.	Write the hospital-based issued I.D. or number to uniquely identify the patient.
5.	Hospital Case No.	Write the hospital-based issued number to uniquely identify each case or incidence.
6	Type of Patient	Check the button for the corresponding type of patient the victim is.
7.	Name of Patient: Last Name, First Name, Middle Name	Write the patient's Last name, First name and Middle name in the appropriate spaces provided. ***Note: None may be written if no informant can provide the information.***
8.	Sex	Check the appropriate box for the sex of the injured by birth.
9.	Civil Status	Check the appropriate box for the civil status of the injured. Not legally separated still to be considered as "Married"
10.	Mother's Maiden Name	Write the mother's name of the patient before marriage. The full middle name must be entered. If there is no middle name, write"N/A".
11.	Permanent Address	Write the patient's permanent address - House No. and Street, Barangay, Municipality/City and Province
11a.	Temporary Address	Write the patient's temporary address - House No. and Street, Barangay, Municipality/City and Province
12,12a, 12b	Landline #, Mobile #, Email Address	Write the patient's contact details such as landline number, mobile number and email address.
13.	Birth Date	Write the date of birth of the patient in the format mm/dd/yyyy (eg. July 1, 1970 should be entered as 07/01/1970)
14.	If Date of Birth is not available (Yrs/Mos/Days)	If date of birth cannot be provided then enter in the space provided the age of the patient in years or months or days.
15.	Place of Birth	Write the Province and the City/Municipality where the patient was born.
16.	Religion	Write the patient's religion
17.	Nationality	Write the patient's nationality
18.	Race	Write the race of the person which describes the skin color, i.e. American (Red Skin), Caucasian (White Skin), Ethiopian (Black Skin), Malay (Brown Skin), Mongolian (Yellow Skin)
19.	Ethnicity	Write the ethnicity of the patient, e.g. Asian, Indian, Pacific Islander, or others
20.	Highest Educational Attainment	Write the highest educational attainment of the patient whether he is elementary, high school, vocational, college, post graduate, or others.
21.	Occupation	Check the appropriate box for the occupation of the injured.
22.	Company	Write the name of the company where the injured is working.
23.	PhilHealth	Write the PhilHealth Number if member or dependent.
24.	Common Reference #	Write the Unified Multi-Purpose ID Common Reference No. if the patient has any. **(UMID CRN can be found in the upgraded, present government IDs such as the SSS, GSIS and Philippine Health Insurance Corp. UMID-CRN is the primary identifier of an individual transacting business or availing of services from any government agency.)**
24 24a-24d	Contact Person (in case of emergency) , Address, Landline #, Mobile #, Email Address	Write the name of the person that may be contacted should any emergency may happen to the patient. Write the address and other contact details such as landline number, mobile number and the email address.
25.	Smoking	Check the button if the patient is smoking cigarettes and how much the patient is consuming per day. Write the age the patient started smoking and the number of years the patient has been smoking.
26.	Second Hand Smoke	Check the button if the patient is exposed to second hand smoke, write the number of years the patient has been exposed to second hand smoking.
27.	Occupational Exposure	Check if the patient has been exposed to any kind of material in relation to the patient's occupation.
28.	Pulmonary Infections	Check if the patient has an infection of TB, if others specify further.
29.	Indoor Air Pollution	Check the button if the patient has been exposed to Indoor Air Pollution. Write the type of Indoor Air Pollutant.
30.	Outdoor Air Pollution	Check the button if the patient has been exposed to Outdoor Air Pollution. Write the type of Outdoor Air Pollutant.
31.	Type of COPD	Write the patient's diagnosed type of COPD.
32.	Referred From	Check the button if the patient came from other hospital or clinic, and was referred to the hospital.
33.	Name of Referring Health Facility	Write the name of the hospital or clinic where the patient came from.
34.	Reason for Referral	Write the reason why the patient was referred to the hospital.
35.	Date of Consultation/Admission	Write the date when the patient first came to the hospital in mm/dd/yyyy format.
36.	Date of Diagnosis	Write the date when the patient was diagnosed with any type or kind of COPD using mm/dd/yyyy format.
37.	Sign/Symptoms	Check the sign/symptoms the patient exhibited during the diagnosis.
38.	Treatment	Write the treatment given to the patient.
39.	Status of Severity	Check the status of severity of the patient's COPD.
40.	Final Diagnosis	Write the patient's final diagnosis.
41.	Final Diagnosis (ICD10-Code)	Write the corresponding ICD10 code for the patient's final diagnosis.
42.	Patient Status	Check the Patient Status whether recovered, improved and unimproved upon discharge.
43.	If Died, underlying cause of death	Write the fundamental cause of death of the patient.
44.	If Died, underlying cause of death, ICD-10 CODE	Write the ICD-10 code for the fundamental cause of death of the patient.
45.	Date of Death	Write the date when the patient died using mm/dd/yyyy format.
46.	Place of Death	Write the province and city/municipality where the patient died.
47.	Final Disposition	Write whether the patient was admitted, discharged, transferred, Discharge against medical advice, treated and sent home, absconded and died.
48.	If transferred, Name of Health Facility	Write the name of the Health Facility where the patient was transferred.
49.	Reason for Referral	Write the reason why the Patient was transferred to another Health facility.
50. 50a. 50b. 50c. 50d.	Consultant in-charge Address Landline # Mobile # Email Address	Write the name, position title /designation of the Consultant in-charge on this portion including the address and contact details (landline no., mobile no. and email address).
51. 51a.	Completed By Address	Write the name, position title /designation of the personnel completing the form on this portion including the address and contact details (landline no., mobile no. and email address).

51b. 51c. 51d.	Landline # Mobile # Email Address	
52.	Date Completed	Write the Date of registry was completed and encoded using the mm/dd/yyyy format.

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Integrated Chronic Non-Communicable Disease Registry System

Annex 3.0

Diabetes Registry Form

Note: Please put N/A for Not Applicable fields. Kindly refer to the instruction on how to fill up the form at the back.

1 National Registry No.

GENERAL DATA

2 Name of Reporting Health Facility	3 Hospital Patient ID No.	4 Hospital Registry No.	5 Hospital Case No.	6 Type of Patient O OPD O In Patient

7 Name of Patient	8 Sex	9 Civil Status
Last Name _____ First Name _____ Middle Name _____	O Female O Male	O Single O Married O Widow/er O Separated O Co-Habitation ☐ Annulled ☐ Divorced

10 **Mother's Maiden Name** Last Name _____ First Name _____ Middle Name _____

11 Permanent Address	12 Landline #
Number & Street Name _____ Region _____ Province _____ City/Municipality _____ Barangay _____ Zip Code _____	12a Mobile #
11a Temporary Address Number & Street Name _____ Region _____ Province _____ City/Municipality _____ Barangay _____ Zip Code _____	12c Email Address

13 Birth Date	14 If Date of Birth is not available	15 Place of Birth (Province,City/Municipality)	16 Religion	18 Race
___/___/___ mm dd yyyy	___Yrs ___ Mos ___ Days		17 Nationality	19 Ethnicity

20 Highest Educational Attainment	21 Occupation	22 Company	23 PhilHealth #	23a Common Reference #

24 Contact Person (in case of emergency) Last Name _____ First Name _____ Middle Name _____	24b Landline #	24d Email Address
24a Address Number & Street Name _____ Region _____ Province _____ City/Municipality _____ Barangay _____ Zip Code _____	24c Mobile #	

PATIENT HISTORY

25 O **Smoking**
- O Less than/Equal to 1 pack consumed per day
- O More than 1 pack consumed/day

Age started Smoking: _____
No. of Years Smoking: _____

25a O **Second Hand Smoke (SHS)**
- O With Exposure to SHS
  Number of Years: _____

26 O **Physical Activity**
- a.Type: _____
- b. Minutes per Exercise Activity: _____
- c. Frequency: O Daily O Weekly O Monthly O Yearly O Quarterly

27 O **Usual/ Typical Diet Intake**
- O **Fish, Meat, Poultry, Egg** Specify _____ Frequency O Daily O Weekly O Monthly O Yearly O Quarterly
- O **Rice, Grains, Bread, Cereals, RootCrops** Specify _____ Frequency O Daily O Weekly O Monthly O Yearly O Quarterly
- O **Fruits/Vegetables** Specify _____ Frequency O Daily O Weekly O Monthly O Yearly O Quarterly
- O **Fats, Oils** Specify _____ Frequency O Daily O Weekly O Monthly O Yearly O Quarterly
- O **Sugar, Sweet** Specify _____ Frequency O Daily O Weekly O Monthly O Yearly O Quarterly
- O **Milk and Milk Products** Specify _____ Frequency O Daily O Weekly O Monthly O Yearly O Quarterly
- O **Others** Specify _____ Frequency O Daily O Weekly O Monthly O Yearly O Quarterly

28 O **Drinking of Alcoholic Beverage**
- a. Type: _____
- b. Amount: _____
- c. Unit of Measure: O Bottle O Glass O Shot
- d. Frequency O Daily O Weekly O Monthly O Yearly O Quarterly

Age started drinking alcohol: _____
No. of Years drinking alcohol: _____

28a **Family Diseases**
☐ Hypertension ☐ CVD ☐ Stroke ☐ Cancer
☐ Asthma ☐ TB ☐ Diabetes
☐ Others, specify _____

28b O **Family History**

Family Member	Type of Diabetes

28c **OB GYNE HISTORY:** No. of Babies >= 8 lbs. _____

28d **OB GYNE HISTORY:** No. of Babies with Congenital Anomalies _____

DIABETES DATA

29 O Referred From	30 Name of Referring Health Facility		31 Reason for Referral
32 Date of Consultation ___/___/___ mm dd yyyy	33a Height in Meter 33b Weight in Kilograms	34a Body Mass Index 34b Classification (BMI)	35a Waist Circumference in centimeters 35b Classification (WC)

36 **Physiological Status for Females** → O Pregnant O Lactating O Not Applicable

37 **Signs and Symptoms** → ☐ Polyuria ☐ Polydipsia ☐ Polyphagia ☐ Weight Loss ☐ Tingling Sensation ☐ Non-Healing Wound ☐ Others, specify _____

38 **Newly or Previously Diagnosed Diabetes:** O Newly Diagnosed O Previously Diagnosed

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39 **Date of Diagnosis:** ____/ ____/ ____ mm dd yyyy	40a. Health Facility Where Diagnosed _____ 40b. Tests Conducted _____ 40c. Duration of Diabetes: _____ O Days O Weeks OMonths OYears OQuarter 40d. Age at Diagnosis: In Years: ____ In Months _____ In Days _____

41 **Type of Diabetes** OType 1 OType 2 OGDM O IGT/IFG O Other, Specify_____

41a **Complications** _____

42 **Current Treatment** a.1 O **Medical Nutrition Therapy** OWith Formal Consult/Education ONo Formal Consult/Education a.2 O **Compliance** O Yes O No	42b. O **Physical Activity** Kind _____ _____ Frequency per Week _____ _____	42c. O **Oral Hypoglycemic** OSulfonylurea OBiguanides OAlpha-glucosidase inhibitor OTZD OOthers, specify _____

42d. O **Insulin** | Type OIntermediate acting OLong acting ORapid acting OVery Rapid acting | Units per Day _____

43 **Surgeries/Operations** → ☐Amputation | ODigital OBKA ☐Revascularization ☐Others, specify _____

44 **Final Diagnosis**	45 **Final Diagnosis: ICD-10 Code**
46 **Patient Status** O Recovered O Improved O Unimproved O Died	
47 **If died, underlying Cause of Death**	48 **If died, underlying Cause of Death: ICD-10 Code**

49 **Date of Death** ____/____/____ (mm/ dd/ yyyy)	50 **Place of Death**	51 **Disposition** O Admitted O Discharge Against Medical Advice O Discharged O Treated and Sent Home O Transferred O Absconded
52 **If Transferred, Name of Health Facility**		53 **Reason for Referral**

54 **Consultant in-charge** _____, _____, _____ _____ (Last Name, First Name, Middle Name, Department) 54a **Address** _____ _____ _____ _____ _____ _____ (Number & Street Name, Region, Province, City/Municipality, Barangay, Zip Code)	54b **Landline #** 54c **Mobile #**	54d **Email Address**
55 **Completed By** _____, _____, _____ _____ (Last Name, First Name, Middle Name, Designation) 55a **Address** _____ _____ _____ _____ _____ _____ (Number & Street Name, Region, Province, City/Municipality, Barangay, Zip Code)	55b **Landline #** 55c **Mobile #**	55d **Email Address** 56 **Date Completed** ____/____/____ mm dd yyyy

Input Instruction Form

Field No.	Field Name	Instruction
1.	**National Registry No.**	Do not fill up. It is a system generated number to uniquely identify each record or data entered into the national registry.
2.	**Name of Reporting Health Facility**	Write the name of the Hospital, Center or Clinic who is submitting the report.
3.	**Hospital Patient I.D. No.**	Write the hospital-based issued I.D. or number to uniquely identify the patient.
4.	**Hospital Registry No.**	Write the hospital-based issued I.D. or number to uniquely identify the patient.
5.	**Hospital Case No.**	Write the hospital-based issued number to uniquely identify each case or incidence.
6	**Type of Patient**	Check the button for the corresponding type of patient the victim is.
7.	**Name of Patient: Last Name, First Name, Middle Name**	Write the patient's Last name, First name and Middle name in the appropriate spaces provided. ***Note: None may be written if no informant can provide the information.***
8.	**Sex**	Check the appropriate box for the sex of the injured by birth.
9.	**Civil Status**	Check the appropriate box for the civil status of the injured. Not legally separated still to be considered as "Married"
10.	**Mother's Maiden Name**	Write the mother's name of the patient before marriage. The full middle name must be entered. If there is no middle name, write"N/A".
11.	**Permanent Address**	Write the patient's permanent address - House No. and Street, Barangay, Municipality/City and Province
11a.	**Temporary Address**	Write the patient's temporary address - House No. and Street, Barangay, Municipality/City and Province
12,12a, 12b	**Landline #, Mobile #, Email Address**	Write the patient's contact details such as landline number, mobile number and email address.
13.	**Birth Date**	Write the date of birth of the patient in the format mm/dd/yyyy (eg. July 1, 1970 should be entered as 07/01/1970)
14.	**If Date of Birth is not available (Yrs/Mos/Days)**	If date of birth cannot be provided then enter in the space provided the age of the patient in years or months or days.
15.	**Place of Birth**	Write the Province and the City/Municipality where the patient was born.
16.	**Religion**	Write the patient's religion
17.	**Nationality**	Write the patient's nationality
18.	**Race**	*Write the race of the person which describes the skin color, i.e. American (Red Skin), Caucasian (White Skin), Ethiopian (Black Skin), Malay (Brown Skin), Mongolian (Yellow Skin)*
19.	**Ethnicity**	Write the ethnicity of the patient, e.g. Asian, Indian, Pacific Islander, or others
20.	**Highest Educational Attainment**	Write the highest educational attainment of the patient whether he is elementary, high school, vocational, college, post graduate, or others.
21.	**Occupation**	Check the appropriate box for the occupation of the injured.
22.	**Company**	Write the name of the company where the injured is working.
23.	**PhilHealth**	Write the PhilHealth Number if member or dependent.
24.	**Common Reference #**	Write the Unified Multi-Purpose ID Common Reference No. if the patient has any. **(UMID CRN can be found in the upgraded, present government IDs such as the SSS, GSIS and Philippine Health Insurance Corp. UMID-CRN is the primary identifier of an individual transacting business or availing of services from any government agency.)**
24 24a-24d	**Contact Person (in case of emergency) , Address, Landline #, Mobile #, Email Address**	Write the name of the person that may be contacted should any emergency may happen to the patient. Write the address and other contact details such as landline number, mobile number and the email address.
25.	**Smoking**	Check the button if the patient is smoking cigarettes and how much the patient is consuming per day. *Write the age the patient started smoking and the number of years the patient has been smoking.*
25a.	**Second Hand Smoke**	Check the button if the patient is exposed to second hand smoke, write the number of years the patient has been exposed to second hand smoking.
26.	**Physical Activity**	Check the button if the patient is undergoing physical activity. Write the type of activities and the frequency each activity is being undertaken by the patient.
27.	**Usual/Typical Diet Intake**	Check and specify the details of the patient's usual/typical diet.
28.	**Drinking of Alcoholic Beverage**	Check the button if the patient is drinking alcohol or beverage. Write the type of alcoholic beverage, amount consumed, unit of measure and frequency, i.e. daily, weekly or monthly per consumption. Write the age the patient started drinking alcohol and the number of years the patient has been drinking.
28a.	**Family Diseases**	Check for the box/es for the type of disease/s the family of the patient has/had been diagnosed of or has a history of.
28b.	**Family History**	Check if the patient has a family history of Diabetes. Identify who among the family member has the diabetes (e.g. mother, father, brother, uncle, grandparent, etc.) Write the type of diabetes the family member has/had been diagnosed of.
28c.	**OB GYNE History (No. of babies >=8 lbs.)**	For female patients who already bore a child or children, write the no. of baby/ies who's weight at birth is equal or greater than 8 lbs.
28d.	**OB GYNE History (No. of babies with Congenital Anomalies)**	For female patients who already bore a child or children, write the no. of baby/ies born with congenital anomalies.
29.	**Referred From**	Check the button if the patient came from other hospital or clinic, and was referred to the hospital.
30.	**Name of Referring Health Facility**	Write the name of the hospital or clinic where the patient came from.
31.	**Reason for Referral**	Write the reason why the patient was referred to the hospital.
32.	**Date of Consultation/Admission**	Write the date when the patient first came to the hospital in mm/dd/yyyy format.
33a.	**Height in Meter**	Write the patient's Height in Meter
33b.	**Weight in Kilograms**	*Write the patient's Weight in Kilograms*
34a.	**Body Mass Index**	Compute for the BMI with the given formula BMI = (Weight in Kilograms / (Height in Meters x Height in Meters)) Then write the computed Body Mass Index
34b.	**Classification (BMI)**	Computation of Classification-BMI: Underweight < 18.5 Normal 18.6 – 22.9 Overweight > 23.0 At risk 23.0 – 24.9 Obese I 25.0 – 29.9 Obese II > 30.0
35a.	**Waist Circumference in Centimeters**	Write the waist circumference in centimeters.

35b.	**Classification (WC)**	Waist Circumference are classified into: Not At Risk (Male: < 90); At Risk (Male: > 90) Not At Risk (Female: < 80); At Risk (Female: > 80)
36.	**Physiological Status for Females**	Check the box weather the patient is pregnant, lactating or not applicable.
37.	**Signs and Symptoms**	Check for the signs/symptoms that the patient has/have exhibited.
38.	**Newly or Previously Diagnosed Diabetes**	Check whether the patient is newly or previously diagnosed with diabetes. ***Note: if previously diagnosed, please answer field nos. 40a to 41***
39.	**Date of Diagnosis**	Write the date when the patient was diagnosed with any type or kind of COPD using mm/dd/yyyy format.
40a.	**Health Facility Where Diagnosed**	Write the name of the facility where the patient was first diagnosed.
40b.	**Tests Conducted**	Write the tests conducted that confirmed the patient is confirmed with diabetes.
40c.	**Duration of Diabetes**	Write how long the patient has been diagnosed with diabetes. Check if the duration of the diagnosis since its
40d.	**Age at Diagnosis**	Write the age when the patient was first diagnosed with diabetes.
41.	**Type of Diabetes**	Check the type of diabetes the patient has been diagnosed with.
41a.	**Complications**	Write the complications in relation to the diabetes the patient has/have if there is any.
42 **a.1** **a.2**	**Current Treatment** **Medical Nutrition Therapy** **Compliance**	 Check if the patient has a Medical Nutrition Therapy, check whether with formal consult or no formal consult. Check YES for compliance if complied and NO if not complied.
42b.	**Physical Activity**	Check if the patient has physical activity/ies, write the kind and the frequency per week.
42c.	**Oral Hypoglycemic**	Check if the patient is taking any oral hypoglycemic drugs, check for the kind of medicine the patient is taking-in.
42d.	**Insulin**	Check if the patient is taking/injecting insulin; write the type and the units per day.
43.	**Surgeries/Operations**	Check for the box for the surgeries/operations the patient has undergone.
44.	**Final Diagnosis**	Write the patient's final diagnosis.
45.	**Final Diagnosis (ICD10-Code)**	Write the corresponding ICD10 code for the patient's final diagnosis.
46.	**Patient Status**	Check the Patient Status whether recovered, improved, unimproved or died upon discharge.
47.	**If Died, underlying cause of death**	Write the fundamental cause of death of the patient.
48.	**If Died, underlying cause of death, ICD-10 CODE**	Write the ICD-10 code for the fundamental cause of death of the patient.
49.	**Date of Death**	Write the date when the patient died using mm/dd/yyyy format.
50.	**Place of Death**	Write the province and city/municipality where the patient died.
51.	**Disposition**	Write whether the patient was admitted, discharged, transferred, Discharge against medical advice, treated and sent home, absconded and died.
52.	**If transferred, Name of Health Facility**	Write the name of the Health Facility where the patient was transferred.
53.	**Reason for Referral**	Write the reason why the Patient was transferred to another Health facility.
54. **54a.** **54b.** **54c.** **54d.**	**Consultant in-charge** **Address** **Landline #** **Mobile #** **Email Address**	Write the name, position title /designation of the Consultant in-charge on this portion including the address and contact details (landline no., mobile no. and email address).
55. **55a.** **55b.** **55c.** **55d.**	**Completed By** **Address** **Landline #** **Mobile #** **Email Address**	Write the name, position title /designation of the personnel completing the form on this portion including the address and contact details (landline no., mobile no. and email address).
56.	**Date Completed**	Write the Date of registry was completed and encoded using the mm/dd/yyyy format.

Annex 4.0

DEPARTMENT OF HEALTH
Integrated Chronic Non-Communicable Disease Registry System

Stroke Registry Form

1 National Registry No.

Note: Please put N/A for Not Applicable fields. Kindly refer to the instruction on how to fill up the form at the back.

GENERAL DATA

2 Name of Reporting Health Facility	3 Hospital Patient ID No.	4 Hospital Registry No.	5 Hospital Case No.	6 Type of Patient
				O OPD O In Patient

7 Name of Patient	8 Sex	9 Civil Status
Last Name / First Name / Middle Name	O Female O Male	O Single O Married O Widow/er O Separated O Co-Habitation ☐ Annulled ☐ Divorced

10 Mother's Maiden Name _____ (Last Name / First Name / Middle Name)

11 Permanent Address	12 Landline #
Number & Street Name / Region / Province / City/Municipality / Barangay / Zip Code	12a Mobile #
11a Temporary Address	12c Email Address
Number & Street Name / Region / Province / City/Municipality / Barangay / Zip Code	

13 Birth Date	14 If Date of Birth is not available	15 Place of Birth (Province,City/Municipality)	16 Religion	18 Race
___/___/___ mm dd yyyy	___Yrs ___ Mos ___ Days		17 Nationality	19 Ethnicity

20 Highest Educational Attainment	21 Occupation	22 Company	23 PhilHealth #	23a Common Reference #

24 Contact Person (in case of emergency)	24b Landline #	24d Email Address
Last Name / First Name / Middle Name		
24a Address	24c Mobile #	
Number & Street Name / Region / Province / City/Municipality / Barangay / Zip Code		

PATIENT HISTORY

25 O **Smoking**
- O Less than/Equal to 1 pack consumed per day
- O More than 1 pack consumed/day

Age started Smoking: _____
No. of Years Smoking: _____

26 O **Physical Activity**

a.Type:_____

b. Minutes per Exercise Activity:

c. Frequency ODaily OWeekly OMonthly OYearly OQuarterly

27O **Usual/ Typical Diet Intake**

- O **Fish, Meat, Poultry, Egg**
  Specify _____
  FrequencyODaily OWeekly OMonthly OYearly OQuarterly
- O **Rice, Grains, Bread, Cereals, RootCrops**
  Specify _____
  FrequencyODaily OWeekly OMonthly OYearly OQuarterly
- O **Fruits/Vegetables**
  Specify _____
  FrequencyODaily OWeekly OMonthly OYearly OQuarterly
- O **Fats, Oils**
  Specify _____
  FrequencyODaily OWeekly OMonthly OYearly OQuarterly
- O **Sugar, Sweet**
  Specify _____
  FrequencyODaily OWeekly OMonthly OYearly OQuarterly
- O **Milk and Milk Products**
  Specify _____
  FrequencyODaily OWeekly OMonthly OYearly OQuarterly
- O **Others**
  Specify _____
  FrequencyODaily OWeekly OMonthly OYearly OQuarterly

28 O **Drinking of Alcoholic Beverage**
- a. Type: _____
- b. Amount: _____
- c. Unit of Measure: O Bottle O Glass O Shot
- d. Frequency: O Daily OWeekly O Monthly O Yearly O Quarterly

Age started drinking alcohol: _____
No. of Years drinking alcohol: _____

29O **Family History**

Family Member	Type of Stroke

29a **Diseases/Attacks**
- ☐ Diabetes Mellitus ☐ Valvular
- ☐ HPN
- ☐ Transient Ischemic Attacks Diseases (RHD)
- ☐ Others, specify_____

STROKE DATA

30 O Referred From	31 Name of Referring Health Facility	32 Reason for Referral

33 **Date of Consultation/Admission** ___/___/___ (mm dd yyyy)
34 **Date of Diagnosis** ___/___/___ (mm dd yyyy)

35 Type of Stroke	36 Presenting Symptoms	
O Ischemic	☐ Headache	☐ Weakness
O Hemorrhagic	☐ Loss of Vision	☐ Loss of consciousness
	☐ Slurred Speech	☐ Numbness or Part Paralysis
	☐ Difficulty in Swallowing	☐ Face ☐ Arm ☐ Leg ☐ Others, specify_____
		☐ Others, specify_____

37 **Treatment**
- O Acute Treatment
  - ☐ Clot Busters tPA
  - ☐ Others, specify_____
- O Preventive Treatment
  - ☐ Anticoagulants/Antiplatelets
  - ☐ Carotid Endarterectomy
  - ☐ Angioplasty/Stents
  - ☐ Others, specify_____
- O For Hemorrhagic Stroke
  - ☐ Surgical Intervention ☐ Others, specify _____
  - ☐ Endovascular Procedures
- O Others, specify_____

DEPARTMENT OF HEALTH
Integrated Chronic Non-Communicable Disease Registry System

38 **Final Diagnosis**		39 **Final Diagnosis: ICD-10 Code**	
40 **Patient Status** O Recovered O Improved O Unimproved O Died			
41 **If died, underlying Cause of Death**		42 **If died, underlying Cause of Death: ICD-10 Code**	
43 **Date of Death** ___/___/____ (mm/ dd/ yyyy)	44 **Place of Death**	45 **Disposition** O Admitted O Discharged O Transferred O Discharge Against Medical Advice O Treated and Sent Home O Absconded	
46 **If Transferred, Name of Health Facility**		47 **Reason for Referral**	
48a **Consultant in-charge** _____ (Last Name), _____ (First Name), _____ (Middle Name) _____ (Department)		48c **Landline #**	48e **Email Address**
48b **Address** _____ (Number & Street Name) _____ (Region) _____ (Province) _____ (City/Municipality) _____ (Barangay) _____ (Zip Code)		49d **Mobile #**	
49 **Completed By** _____ (Last Name), _____ (First Name), _____ (Middle Name) _____ (Designation)		49b **Landline #**	49d **Email Address**
49a **Address** _____ (Number & Street Name) _____ (Region) _____ (Province) _____ (City/Municipality) _____ (Barangay) _____ (Zip Code)		49c **Mobile #**	50 **Date Completed** ___/___/___ mm dd yyyy

DEPARTMENT OF HEALTH
Integrated Chronic Non-Communicable Disease Registry System

Input Instruction Form

Field No.	Field Name	Instruction
1.	National Registry No.	Do not fill up. It is a system generated number to uniquely identify each record or data entered into the national registry.
2.	Name of Reporting Health Facility	Write the name of the Hospital, Center or Clinic who is submitting the report.
3.	Hospital Patient I.D. No.	Write the hospital-based issued I.D. or number to uniquely identify the patient.
4.	Hospital Registry No.	Write the hospital-based issued I.D. or number to uniquely identify the patient.
5.	Hospital Case No.	Write the hospital-based issued number to uniquely identify each case or incidence.
6	Type of Patient	Check the button for the corresponding type of patient the victim is.
7.	Name of Patient: Last Name, First Name, Middle Name	Write the patient's Last name, First name and Middle name in the appropriate spaces provided. ***Note: None may be written if no informant can provide the information.***
8.	Sex	Check the appropriate box for the sex of the injured by birth.
9.	Civil Status	Check the appropriate box for the civil status of the injured. Not legally separated still to be considered as "Married"
10.	Mother's Maiden Name	Write the mother's name of the patient before marriage. The full middle name must be entered. If there is no middle name, write"N/A".
11.	Permanent Address	Write the patient's permanent address - House No. and Street, Barangay, Municipality/City and Province
11a.	Temporary Address	Write the patient's temporary address - House No. and Street, Barangay, Municipality/City and Province
12,12a, 12b	Landline #, Mobile #, Email Address	Write the patient's contact details such as landline number, mobile number and email address.
13.	Birth Date	Write the date of birth of the patient in the format mm/dd/yyyy (eg. July 1, 1970 should be entered as 07/01/1970)
14.	If Date of Birth is not available (Yrs/Mos/Days)	If date of birth cannot be provided then enter in the space provided the age of the patient in years or months or days.
15.	Place of Birth	Write the Province and the City/Municipality where the patient was born.
16.	Religion	Write the patient's religion
17.	Nationality	Write the patient's nationality
18.	Race	Write the race of the person which describes the skin color, i.e. American (Red Skin), Caucasian (White Skin), Ethiopian (Black Skin), Malay (Brown Skin), Mongolian (Yellow Skin)
19.	Ethnicity	Write the ethnicity of the patient, e.g. Asian, Indian, Pacific Islander, or others
20.	Highest Educational Attainment	Write the highest educational attainment of the patient whether he is elementary, high school, vocational, college, post graduate, or others.
21.	Occupation	Check the appropriate box for the occupation of the injured.
22.	Company	Write the name of the company where the injured is working.
23.	PhilHealth	Write the PhilHealth Number if member or dependent.
24.	Common Reference #	Write the Unified Multi-Purpose ID Common Reference No. if the patient has any. **(UMID CRN can be found in the upgraded, present government IDs such as the SSS, GSIS and Philippine Health Insurance Corp. UMID-CRN is the primary identifier of an individual transacting business or availing of services from any government agency.)**
24 24a-24d	Contact Person (in case of emergency) , Address, Landline #, Mobile #, Email Address	Write the name of the person that may be contacted should any emergency may happen to the patient. Write the address and other contact details such as landline number, mobile number and the email address.
25.	Smoking	Check the button if the patient is smoking cigarettes and how much the patient is consuming per day. Write the age the patient started smoking and the number of years the patient has been smoking.
26.	Physical Activity	Check the button if the patient is undergoing physical activity. Write the type of activities and the frequency each activity is being undertaken by the patient.
27.	Usual/Typical Diet Intake	Check and specify the details of the patient's usual/typical diet.
28.	Drinking of Alcoholic Beverage	Check the button if the patient is drinking alcohol or beverage. Write the type of alcoholic beverage, amount consumed, unit of measure and frequency, i.e. daily, weekly or monthly per consumption. Write the age the patient started drinking alcohol and the number of years the patient has been drinking.
29.	Family History	Check if the patient has a family history of Diabetes. Identify who among the family member has the diabetes (e.g. mother, father, brother, uncle, grandparent, etc.) Write the type of diabetes the family member has/had been diagnosed of.
29a.	Diseases/Attacks	Check for the box/es for the type of disease/s the family of the patient has/had been diagnosed of or has a history of.
30.	Referred From	Check the button if the patient came from other hospital or clinic, and was referred to the hospital.
31.	Name of Referring Health Facility	Write the name of the hospital or clinic where the patient came from.
32.	Reason for Referral	Write the reason why the patient was referred to the hospital.
33.	Date of Consultation/Admission	Write the date when the patient first came to the hospital in mm/dd/yyyy format.
34.	Date of Diagnosis	Write the date when the patient was diagnosed with any type or kind of COPD using mm/dd/yyyy format.
35.	Type of Stroke	Check what type of stroke the patient has been diagnosed with.
36.	Presenting Symptoms	Check the presenting symptoms the patient exhibited.
37.	Treatment	Check what kind of treatment has been administered to the patient.
38.	Final Diagnosis	Write the patient's final diagnosis.
39.	Final Diagnosis (ICD10-Code)	Write the corresponding ICD10 code for the patient's final diagnosis.
40.	Patient Status	Check the Patient Status whether recovered, improved, unimproved or died upon discharge.
41	If Died, underlying cause of death	Write the fundamental cause of death of the patient.
42.	If Died, underlying cause of death, ICD-10 CODE	Write the ICD-10 code for the fundamental cause of death of the patient.
43.	Date of Death	Write the date when the patient died using mm/dd/yyyy format.
44.	Place of Death	Write the province and city/municipality where the patient died.
45.	Disposition	Write whether the patient was admitted, discharged, transferred, Discharge against medical advice, treated and sent home, absconded and died.
46.	If transferred, Name of Health Facility	Write the name of the Health Facility where the patient was transferred.
47.	Reason for Referral	Write the reason why the Patient was transferred to another Health facility.
48. 48a. 48b. 49c. 49d.	Consultant in-charge Address Landline # Mobile # Email Address	Write the name, position title /designation of the Consultant in-charge on this portion including the address and contact details (landline no., mobile no. and email address).

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Integrated Chronic Non-Communicable Disease Registry System

49. **49a.** **49b.** **49c.** **49d.**	**Completed By** **Address** **Landline #** **Mobile #** **Email Address**	Write the name, position title /designation of the personnel completing the form on this portion including the address and contact details (landline no., mobile no. and email address).
50.	**Date Completed**	Write the Date of registry was completed and encoded using the mm/dd/yyyy format.

DEPARTMENT OF HEALTH
Online Na onal Electronic Injury Surveillance System

Patient Injury Form

Note: Please put N/A for Not Applicable elds. Kindly refer at the back of this page for the instruc ons on how to ll up the form.

1 **Registry No.**

GENERAL DATA

2 **Name of Repor ng Health Facility**	3 **Hospital Pa ent ID No.**	4 **Hospital Registry No.**	5 **Hospital Case No.**

6 **Type of Pa ent** O ER O OPD☐ New Case ☐ Revisit O In-Pa ent (injury sustained during con nement) O BHS O RHU

6a **Informant** ☐ Self (Pa ent/Injured) ☐ Family member ☐ Police ☐ Others, specify _____ ☐ None

7 **Name of Pa ent**
Last Name _____ First Name _____ Middle Name _____

8 **Sex**
O Female
O Male

9 **Civil Status**
O Single O Married
O Widow/er O Separated
O Live-in ☐ Annulled ☐ Divorced

10 **Mother's Maiden Name** Last Name _____ First Name _____ Middle Name _____

11 **Permanent Address**
Number & Street Name _____ Region _____ Province _____ City/Municipality _____ Barangay _____ Zip Code _____

12 **Landline #**

12a **Mobile #**

11a **Temporary Address**
Number & Street Name _____ Region _____ Province _____ City/Municipality _____ Barangay _____ Zip Code _____

12c **Email Address**

13 **Birth Date**	14 **If Date of Birth is not available**	15 **Place of Birth** (Province,City/Municipality)	16 **Religion**	18 **Race**
___/___/_____ mm dd yyyy	_____Yrs ____ Mos ____ Days		17 **Na onality**	19 **Ethnicity**

20 **Highest Educa onal A ainment**	21 **Occupa on**	22 **Company**	23 **PhilHealth #**	23a **Common Reference #**
☐ No formal educa on ☐ College Level/Graduate ☐ Elementary Level/Graduate ☐ High School Level/Graduate ☐ Voca onal ☐ Post Graduate	☐ Employed ☐ None/Unemployed ☐ Unknown ☐ Student ☐ Others, specify:_____			

24 **Contact Person** (in case of emergency) Last Name _____ First Name _____ Middle Name _____

24b **Landline #**

24d **Email Address**

24a **Address**
Number & Street Name _____ Region _____ Province _____ City/Municipality _____ Barangay _____ Zip Code _____

24c **Mobile #**

PRE-ADMISSION DATA: (also applicable for BHS/RHU cases)

25 **Place of Injury:**
No. & Street:_____
Region:_____
Province:_____
Municipality/City:_____
Barangay: _____ Zip code _____

26 **Date of Injury:**__ __/ __ __ / ____ mm dd yyyy

27 **Time:** _____**hr** (military me to be entered)

28 **Date of Consulta on:**__ __/ __ __ / ____ mm dd yyyy

29 **Time:** _____**hr** (military me to be entered)

30 **Injury Intent:**
☐ Uninten onal/Accidental
☐ Inten onal(violence)
☐ VAWC Pa ent
☐ Inten onal(self-in icted)
☐ Undetermined

31 **First Aid Given:** ☐ Yes, What: _____ By whom: _____ ☐ No

32 **Nature of Injury/ies:**
Mul ple injuries? ☐ **Yes** ☐ **No**
(Check all applicable, indicate in the blank space opposite each type of injury the body loca on (site) a ected 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/ Lacera on _____
(ex. hacking, gunshot, stabbing, animal (dog, cat, rat, snake, etc) bites, human bites, insect bites, punctured wound, etc)
☐ Trauma c Amputa on _____
☐ Others: Pls. specify injury and the body part/s a ected: _____

33 **External Cause/s of Injury/ies:**
☐ Bites/s ngs, Specify animal/insect: _____
☐ Burns, __ Heat __ Fire __ Electricity __ Oil __ Fric on __ Others, specify _____
☐ Chemical/substance, specify _____
☐ Contact with sharp objects, specify object _____
☐ Drowning: Type/Body of Water: __ Sea __ River __ Lake __ Pool __ Bath Tub __ Others: , specify: _____
☐ Exposure to forces of nature: __ Earthquake __ Volcanic erup on __ Typhoon __ Landslide/Avalanche __ Tidal wave
__ Flood (due to storm/excessive rain) __ Others, specify _____
☐ Fall , specify, from/in/on/into _____
☐ Gunshot, specify weapon _____
☐ Hanging/Strangula on
☐ Mauling/Assault
☐ Transport /Vehicular Accident

DEPARTMENT OF HEALTH
Online Na onal Electronic Injury Surveillance System

☐ Firecracker, specify type/s _____ (with libraries)
☐ Sexual Assault/ Sexual Abuse/ Rape (Alleged)
☐ Others, specify _____

(33a) FOR TRANSPORT/VEHICULAR ACCIDENT ONLY: ☐ Land ☐ Water ☐ Air ☐ Collision ☐ Non-Collision

(33a.1) Severity: ☐ Fatal Accident ☐ Serious Injury Accident ☐ Minor Injury Accident ☐ Property Damage Only

(33a.2) Vehicles Involved:
Patient's Vehicle ☐ None (Pedestrian) ☐ Car ☐ Van ☐ Bus ☐ Motorcycle ☐ Bicycle ☐ Tricycle ☐ Others, _____ ☐ unknown
Other Vehicle/Object Involved (for COLLISION accident ONLY) ☐ None (Pedestrian) ☐ Car ☐ Van ☐ Bus ☐ Motorcycle ☐ Bicycle ☐ Tricycle ☐ Others, _____ ☐ unknown

(33a.3) Posi on of Pa ent
☐ Pedestrian
☐ Driver ☐ Captain ☐ Pilot
☐ Front passenger
☐ Rear passenger
☐ Others, _____
☐ Unknown

(33 a.4) Vic ms Involved
☐ Alone
☐ With others, specify how many (excluding the vic m). _____

(33b) **Place of Occurrence:**
☐ Home
☐ School
☐ Road
☐ Videoke Bars
☐ Workplace, specify _____
☐ Others, specify _____
☐ Unknown

(33c) **Ac vity of the Pa ent at the me of the incident:**
☐ Sports
☐ Leisure
☐ Work related
☐ Others, _____
☐ Unknown

(33d) Other risk factors at the me of the incident:
☐ Alcohol/liquor
☐ Smoking
☐ Drugs
☐ Using mobile phone
☐ Sleepy
☐ Others, specify _____
(e.g. suspected under the in uence of substance used)

(33e) **Safety:** (check all that apply) ☐ None ☐ Airbag ☐ Helmet ☐ Childseat ☐ Seatbelt ☐ Life vest/Lifejacket/Floata on device (for drowning) ☐ Others, _____ ☐ Unknown

HOSPITAL/FACILITY DATA:
A. ER/OPD/BHS/RHU

34 **Transferred from another hospital/facility** ☐ Yes ☐ No

35 **Referred by another Hospital /Facility for Laboratory and/or other medical procedures** ☐ Yes ☐ No

36 **Name of Origina ng Hospital/Physician** :

37 **Status upon reaching Facility/Hospital:** ☐ Dead on Arrival ☐ Alive : If alive, please check if: ___ Conscious ___ Unconscious

38 **Mode of transport to the Hospital/Facility:** ☐ Ambulance ☐ Police vehicle ☐ Private vehicle ☐ Others, specify: _____

39 **Ini al Impression:**

40 **ICD-10 Code/s: Nature of Injury :**	41 **ICD-10 Code/s: External cause of Injury:**

42 **Treatment Given :** ☐ Yes, specify: _____ ☐ No

43 **Disposi on**
☐ Admi ed ☐ Treated and Sent Home ☐ Transferred to another facility/hospital, specify: _____
☐ HAMA ☐ Absconded

44 **Outcome** ☐ Improved ☐ Unimproved ☐ Died

B. IN-PATIENT (for admi ed hospital cases only)

45 **Complete Final Diagnosis:** _____

46 **Disposi on** ☐ Discharged ☐ HAMA ☐ Absconded ☐ Others, specify: _____
☐ Transferred to another facility/hospital, specify: _____

47 **Outcome** ☐ Improved ☐ Unimproved ☐ Died

48 **ICD-10 Code/s: Nature of Injury :**	49 **ICD-10 Code/s: External cause of Injury:**

50 **Comments:**

51 **Consultant in-charge** _____ (Last Name) _____ (First Name) _____ (Middle Name) _____ (Department)	51b **Landline #**	51d **Email Address**
51a **Address** _____ (Number & Street Name) _____ (Region) _____ (Province) _____ (City/Municipality) _____ (Barangay) _____ (Zip Code)	51c **Mobile #**	
52 **Completed By** _____ (Last Name) _____ (First Name) _____ (Middle Name) _____ (Department)	52b **Landline #**	52d **Email Address**
52a **Address** _____ (Number & Street Name) _____ (Region) _____ (Province) _____ (City/Municipality) _____ (Barangay) _____ (Zip Code)	52c **Mobile #**	53 **Date Completed** ___/___/___ (mm dd yyyy)

DEPARTMENT OF HEALTH
Online Na onal Electronic Injury Surveillance System

Input instruc on Form

No.	Field Name	Instruc on
1	**Registry No.**	This is a system-generated number assigned by the NEISS so ware. Once the injury report is encoded into the system, copy the system-generated number and write on this box.
2	**Name of Repor ng Health Facility**	Write the name of the Hospital, Center or Clinic who is submi ng the report.
3	**Hospital Pa ent ID No.**	Write the hospital-based issued I.D. or number to uniquely iden fy the pa ent.
4	**Hospital Registry No.**	Write the hospital-based issued I.D. or number to uniquely iden fy the pa ent.
5	**Hospital Case No.**	Write the hospital-based issued number to uniquely iden fy each case or incidence.
6	**Type of Pa ent**	Check the bu on for the corresponding type of pa ent the vic m is.
6a	**Informant**	Check the appropriate box for the details on the informant, if the information were provided by the injured then "Self" should be ticked or if no informant tick "None"
7	**Name of Pa ent**	Write the patient's Last name, First name and Middle name in the appropriate spaces provided. ***Note: Mr. X or None may be wri en if no informant can provide the informa on.***
8	**Sex**	Check the appropriate box for the sex of the injured by birth.
9	**Civil Status**	Check the appropriate box for the civil status of the injured. Not legally separated s ll to be considered as "Married"
10	**Mother's Maiden Name**	Write the mother's name of the patient before marriage. The full middle name must be entered. If there is no middle name, write"N/A".
11	**Permanent Address**	Write the patient's permanent address - House No. and Street, Barangay, Municipality/City and Province
11a	**Temporary Address**	Write the patient's temporary address - House No. and Street, Barangay, Municipality/City and Province
12 12a-12b	**Landline #, Mobile #, Email Address**	Write the patient's contact details such as landline number, mobile number and email address.
13	**Birth Date**	Write the date of birth of the pa ent in the format mm/dd/yyyy (eg. July 1, 1970 should be entered as 07/01/1970)
14	**If Date of Birth is not available**	If date of birth cannot be provided then enter in the space provided the age of the pa ent in years or months or days.
15	**Place of Birth**	Write the Province and the City/Municipality where the pa ent was born.
16	**Religion**	Write the patient's religion
17	**Na onality**	Write the patient's nationality
18	**Race**	Write the race of the person which describes the skin color, i.e. American (Red Skin), Caucasian (White Skin), Ethiopian (Black Skin), Malay (Brown Skin), Mongolian (Yellow Skin)
19	**Ethnicity**	Write the ethnicity of the pa ent, e.g. Asian, Indian, Paci c Islander, or others
20	**Highest Educa onal A ainment**	Write the highest educa onal a ainment of the pa ent whether he is elementary, high school, voca onal, college, post graduate, or others.
21	**Occupa on**	Check the appropriate box for the occupa on of the injured.
22	**Company**	Write the name of the company where the injured is working.
23	**PhilHealth #**	Write the PhilHealth Number if member or dependent.
23a	**Common Reference #**	Write the Uni ed Mul -Purpose ID Common Reference No. if the pa ent has any. **(UMID CRN can be found in the upgraded, present government IDs such as the SSS, GSIS and Philippine Health Insurance Corp. UMID-CRN is the primary iden er of an individual transac ng business or availing of services from any government agency.)**
24 24a-24d	**Contact Person (in case of emergency) , Address, Landline #, Mobile #, Email Address**	Write the name of the person that may be contacted should any emergency may happen to the pa ent. Write the address and other contact details such as landline number, mobile number and the email address.
25	**Place of Injury:**	Write the loca on or place where the injury occurred speci cally the Street, Barangay, Municipality/City, Province and Region.
26-27	**Date and Time of Injury:**	Write the date of occurrence of the injury in the format mm/dd/yyyy (eg. July 1, 2007 should be entered as 07/01/2007.)
28 29	**Date of Consulta on:** **Time:**	Write the date of consult of the pa ent in the facility in the format mm/dd/yyyy (eg. July 1, 2007 should be entered as 07/01/2007.) Write the me of consult of the pa ent in military me (eg. 8:00 am should be entered as 0800 hr and 8:00 pm as 2000 hr)
30	**Injury Intent:**	Check the appropriate box for the intent of injury whether it was caused by an act carried out on purpose by oneself or by another person(s), with the goal of injuring or killing or the injury was unintended / accidental. **Uninten onal/Accidental:** Injury that is not in icted by deliberate means (eg. not on purpose). This category includes those injuries described as unintended or " accidental", regardless of whether the injury was inflicted by oneself or by another person. **Inten onal (self in icted):** Injury resul ng from a deliberate violent act (*Intentional-self inflicted*) in icted on oneself with the intent to take one's life or harm oneself (eg. self injury, suicide, suicide attempt). **Inten onal (violence):** It includes assault (*Intentional-violence)* which is an act of violence by one or more persons where physical force or any means is used with the intent of causing harm, injury or death to another person and legal interven ons caused by police or other legal authori es during law enforcement ac vi es. **VAWC pa ent:** It refers to violence against women and children, like sexual abuse, physical abuse etc. **Undetermined:** Injury resul ng from an unknown or undetermined intent.
31	**First Aid Given:**	Check the appropriate box to indicate whether rst aid was given to the injured at the site of the event. If yes is checked, write the rst aid given and by whom.
32	**Nature of Injury/ies:**	First, check the appropriate box to indicate whether it is a case of mul ple injuries or not then check the appropriate box (es) for the speci c injury (ies) sustained by the pa ent. For each type of injury selected or checked, the a ected body loca on or site as well as other important details of the injury must also be wri en on the space provided opposite each type of injury.
33	**External Cause/s of Injury/ies:**	Check the appropriate box for the cause or mechanism of injury that is the way in which the person sustained the injury; how the person was injured or the process by which the injury occurred. • **Bites/s ngs**: refer to poisonous or non-poisonous bite or s ng through the skin. This includes human bite, dog bite, cat bite, snake bite, insect bite, s ngs from coral or jelly sh or bites and s ngs by other plants and animals. ***Note: If this is selected, the speci c animal/insect/plant that caused the bite/s ng must be indicated.*** • **Burns:** refer to the external causes such as heat, electricity, chemicals, light, radia on, and fric on, severe exposure to ames or heat leading to damage in the skin or places deeper in the body. ***Note: If this is selected, check the appropriate box for the speci c agent that caused the injury.*** • **Chemical/substances**: refer to exposure to chemicals / substances. This includes exposure, inhala on, inges on and absorp on of chemicals, drugs and other substances. However, this does not include harmful e ects from normal therapeu c drugs (adverse e ects). ***Note: If this is selected, the speci c chemicals/substances that caused the injury must be indicated.*** • **Contact with sharp object**: External causes such as incision, slash, perfora on, or puncture by a pointed or sharp instrument, weapon or object (eg. knife, needle). • **Drowning**: refers to su oca on resul ng from submersion in water or another liquid. ***Note: If this is selected, check the appropriate box for the speci c type/body of water where the drowning occurred.*** • **Exposure to forces of nature:** refers to exposure to an event or condi on of natural or environmental cause such as earthquake, volcanic erup on and other similar natural calami es/disasters. • **Fall:** refers to the abrupt descent of a person due to the force of gravity and strikes a surface at the same or lower level. ***Note: If this is selected, informa on as to where the pa ent fall from/ in/ on into must be indicated (eg. tree, manhole, escalator, stairs).*** • **Firecracker:** refers to external cause due to any type of recracker. ***Note: If this is selected, the speci c type of recracker must be indicated.***

DEPARTMENT OF HEALTH
Online Na onal Electronic Injury Surveillance System

		• **Gunshot:** a penetra ng force resul ng from a bullet or other projec le shot from a powder-charged gun or pellet gun (eg. Handguns, shotguns, ri es, pellet gun/ri e or pistol. ***Note: If this is selected, the speci c type of weapon used must be indicated.*** • **Hanging/Strangula on:** refers to suspension of a person by a cord or anything used for tying. Also includes strangling with the hands, ngers, or other extremi es and strangling with some form of cord or cloth such as rope, wire, or shoe laces, either par ally or fully circumferencing the neck. • **Mauling/Assault:** is an act of violence by one or more persons where physical force or any means is used with the intent of causing harm, injury or death to another person. Does not include sexual assault, there is a separate box for sexual assault. • **Transport / Vehicular Accident:** an external cause of injury involving modes of transporta on (land, air and water). ***Note: If this is selected, answers to sec on 33a are required.*** • **Sexual Assault/Sexual Abuse/Rape (Alleged):** an **assault** of a **sexual** nature on another person, or any **sexual** act commi ed without consent. • **Others:** refer to other external causes of injury that do not t in any of the above categories (eg. Opera ng machinery, foreign body, hit by falling objects, etc.). **Note:** If this is selected, the speci c cause of injury must be indicated.
(33a)	**FOR TRANSPORT/VEHICULAR ACCIDENT ONLY:**	**This sec on is only for cases of transport/vehicular accidents.** Check the appropriate box to indicate whether the transport/vehicular accident either land, water or air transport accident. Check the appropriate box to indicate whether the transport/vehicular accident is collision or non collision transport accident.
(33a.1)	**Severity**	Check the appropriate box for the severity of the injury sustained by the pa ent
(33a.2)	**Vehicles Involved:**	Check the appropriate box for the vehicle used by the vic m/pa ent and the other vehicle involved, if any when the accident occurred. ***Note: If the vic m/pa ent was a pedestrian or was not riding any vehicle when the accident occurred check the box for "none". If the vic m/pa ent was riding any other speci ed vehicle that does not t in any of the above categories for vehicle check the box for "others" and indicate the speci c vehicle.***
(33a.3)	**Posi on of Pa ent**	Check the appropriate box for the posi on of the vic m/pa ent in the vehicle when the accident occurred
(33 a.4)	**Vic ms Involved**	Check the appropriate box to indicate whether the victim/patient was alone or with others at the time of the accident. If "with others" is checked, specify the number of other vic ms involved
(33b)	**Place of Occurrence:**	Check the appropriate box to indicate the place of occurrence of the external cause whether it occurred at home, school, road, videoke bar, workplace or other speci ed place. ***Note: If the place of occurrence checked is workplace, the name of the company / o ce / establishment must be speci ed. If the external cause occurred in places other than those specified then check "others" and indicate the specific place of occurrence (e.g. Mall, restaurant)***
(33c)	**Ac vity of the Pa ent at the me of the incident:**	Check the appropriate box to indicate the ac vity of the vic m/pa ent at the me of the incident.
(33d)	**Other risk factors at the me of the incident:**	Check the appropriate box (es) for other risk factors at the me of the incident. **(Mul ple answers allowed)**
(33e)	**Safety:**	Check the appropriate box (es) for the safety accessories in the vehicle used by the vic m / pa ent when the accident occurred. (Mul ple answers allowed)
34	**Transferred from another hospital/facility**	Check the appropriate box to indicate whether the pa ent was transferred from another facility/hospital. **If "yes" is checked, answer to item no. 36 is required.**
35	**Referred by another Hospital /Facility for Laboratory and/or other medical procedures**	Check the appropriate box to indicate whether the pa ent was referred by another hospital/ facility for laboratory and other medical procedures. **If "yes" is checked, answer to item no. 36 is required.**
36	**Name of Origina ng Hospital/Physician**	Enter the name of the origina ng hospital or physician
37	**Status upon reaching Facility/Hospital**	Check the appropriate box to indicate the status of the patient upon reaching Hospital/facility. if "Alive", check whether the injured was conscious or unconscious
38	**Mode of transport to the Hospital/Facility**	Check the appropriate box for the mode of transport of the injured to the hospital or facility.
39	**Ini al Impression**	Enter the initial impression on the patient's condition.
40	**ICD-10 Code/s: Nature of Injury :**	Enter the complete ICD-10 code (s) for the nature of injury following the ICD-10 coding rules and guidelines (Most of the codes should be within S00-T98). If there are mul ple injuries, write the code for the mul ple injuries rst if there is any, unless a special coding rule applies, and followed by the codes for the individual injuries.
41	**ICD-10 Code/s: External cause of Injury:**	Enter the complete ICD-10 code (s) for the external cause of injury following the ICD-10 coding rules and guidelines (Codes should be within V01- Y36, Y85-Y87, and Y89). Place of occurrence and ac vity codes must also be provided if applicable. (Code (s) entered in Item No. 40 may just be copied here).
42	**Treatment Given**	Check whether any treatment was given to the injured in the ER/OPD or BHS/RHU. If "yes", write the specific treatment given.
43	**Disposi on**	Check the appropriate box to indicate the status (disposi on) of the pa ent at the me of release from ER/OPD or BHS/RHU. ***Note: If admi ed, sec on B. IN-PATIENT must be lled up; otherwise there is no need to fill up said section. . If "transferred", write the name of hospital/facility where the injured was transferred***
44	**Outcome**	Check the appropriate box to indicate the outcome of the patient's condition at the me of release from ER/OPD or BHS/RHU. If the outcome is either improved or unimproved then proceed to the next items, if the outcome is "died", skip to the item on Comments.
45	**Complete Final Diagnosis:**	Enter the complete nal diagnosis of the pa ent.
46	**Disposi on**	Check the appropriate box to indicate the status (disposi on) of the pa ent at the me of Discharge.
47	**Outcome**	Check the appropriate box to indicate the outcome of the patient's condition at the me of discharge.
48	**ICD-10 Code/s: Nature of Injury :**	Enter the complete ICD-10 code (s) for the complete nal diagnosis following the ICD- 10 coding rules and guidelines (Most of the codes should be within (S00-T98). If there are mul ple injuries, write the code for the mul ple injuries rst if there is any, unless a special coding rule applies, and followed by the codes for the individual injuries.
49	**ICD-10 Code/s: External cause of Injury:**	Enter the complete ICD-10 code (s) for the external cause of injury following the ICD-10 coding rules and guidelines (Codes should be within V01- Y36, Y85-Y87, Y89). Place of occurrence and ac vity codes must also be provided if applicable. (Code (s) entered in Item No. 41 may just be copied here).
50	**Comments:**	Enter other comment (s) regarding the case
51 51a 51b 51c 51d	**Consultant in-charge** **Address** **Landline #** **Mobile #** **Email Address**	The posi on tle /designa on of the Consultant in-charge must be entered on this por on including the address and contact details (landline no., mobile no. and email address).
52 52a 52b 52c 52d	**Completed By** **Address** **Landline #** **Mobile #** **Email Address**	The posi on tle /designa on of the personnel comple ng the form must be entered on this por on including the address and contact details (landline no., mobile no. and email address). The name and signature of the personnel comple ng the form must be entered on this por on.
53	**Date Completed**	The date when the form was accomplished must be entered on this por on.

DEPARTMENT OF HEALTH
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:**	**Date of Consultation:** **Time of Consultation:**	**Place of Occurrence:**
__ __/ __ __/ ____ ____:____:____	__ __/ __ __/ ____ __ __:__ __:__ __	◯ Home ◯ Street ◯ Other, specify: _____
m m d d yyyy hh mm ss	**m m d d yyyy hh mm ss**	

Address of Occurrence: **House No. & Street:** **Barangay:** **Municipality/City:** **Province:**

Type of Involvement:	**Nature of Injury:**
◯ Active ◯ Passive	◯ Fireworks-related ◯ GSW-Straybullet ◯ Tetanus ◯ Fireworks ingestion ◯ Unknown ◯ Other, specify: _____
Multiple Injuries: (fill up, if fireworks related) ◯ Yes ◯ No	**Diagnosis(to include nature and site):**
If fireworks related, type of injury: (can be multiple) ☐ Blast/Burn WITH amputation ☐ Blast/Burn NO amputation ☐ Eye Injury ☐ Other, specify: _____	

Anatomical Location:	**Name of Firecracker:**	**Liquor Intoxication:**
		◯ Yes ◯ No

Treatment Given:	**Disposition:**
◯ ATS ◯ ATS/Toxoid ◯ HTig ◯ HTig/Toxoid ◯ Toxoid ◯ None ◯ Other, specify: _____	◯ Absconded ◯ Admitted ◯ 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:**

Input instruction Form

No.	Field Name	Instruction
1	**Date:**	The date when the form was accomplished must be entered on this portion.
2	**Region:**	Write the region where the hospital is located.
3	**Hospital**	Write the name of the Hospital, Center or Clinic which submits the report.
4	**Name of Patient**	Write the patient's Last name, First name and Middle name on the appropriate spaces provided. ***Note: Mr. X or None may be written if no informant can provide the information.***
5	**Permanent Address**	Write the patient's permanent address - House No. and Street, Barangay, Municipality/City and Province
6	**Telephone No.:**	Write the patient's contact details such as landline number, mobile number
7	**Sex**	Check the appropriate box for the sex of the injured by birth.
8	**Age:**	Write the age of the patient in years, months and days.
9-10	**Date and Time of Injury:**	Write the date of occurrence of the injury in the format mm/dd/yyyy (eg. July 1, 2007 should be entered as 07/01/2007.) (Note: Date of injury is not greater than date of consultation)
11-12	**Date of Consultation:** **Time:**	Write the date of consultation of the patient in the facility in the format mm/dd/yyyy (eg. July 1, 2007 should be entered as 07/01/2007.) Write the time of consult of the patient in military time (eg. 8:00 am should be entered as 0800 hr and 8:00 pm as 2000 hr)
13	**Place of Occurrence:**	Check the appropriate place where the injury occurred- home, street, if others please specify.
14	**Address of Occurrence:**	Write the location or place where the injury occurred, specifically the Street, Barangay, Municipality/City, Province and Region.
15	**Type of Involvement:**	Check the appropriate type of involvement whether the patient is active or passive.
16	**Nature of Injury:**	Check the appropriate specific nature of injury(ies) sustained by the patient. Whether fireworks related injury, GSW-Straybullet, tetanus, fireworks ingestion, unknown, if others, please specify. (Note: If fireworks related injury, please answer No. 17and 18
17	**Multiple Injury/ies:**	Check the appropriate choice to indicate whether it is a case of multiple injuries or not sustained by the patient.
18	**If Fireworks Related-** **Type of Injury/ies:**	Check the appropriate box which type of injury sustained by the patient is. (Note: It can be multiple)
19	**Diagnosis:**	Enter the complete final diagnosis of the patient as well as other important details of the injury must also be written on this portion.
20	**Anatomical Location**	Write the affected body location or site.
21	**Name of Firecracker:**	Write the name of firecracker/s which causes the injury.
22	**Liquor Intoxication**	Check whether the patient is intoxicated with liquor or not.
23	**Treatment Given:**	Check the appropriate choice to indicate what kind of treatment is given to the patient
24	**Disposition**	Check the appropriate choice to indicate the status (disposition) of the patient at the time of release ***. If "transferred", write the name of hospital/facility where the injured was transferred***
25	**Prepared by:**	The name and signature of the personnel completing the form must be entered on this portion.
26	**Noted by:**	The name and signature of the Officer in-charge must be entered on this portion.

DEPARTMENT OF HEALTH
Violence Against Women and Children Registry Form

Annex 7.0

Note: Please put N/A for Not Applicable fields. Kindly refer at the back of this page for the instructions on how to fill up the form.

1 **VAWC Registry No.**

GENERAL DATA

2 **Name of Reporting Health Facility** | 3 **Hospital Patient ID No.** | 4 **Hospital Registry No.** | 5 **Hospital Case No.** | 6 **Type of Patient** O ER O Referral O OPD O RHU ☐ New Case ☐ Revisit

7 **Name of Patient** _____ (Last Name) _____ (First Name) _____ (Middle Name)

8 **Sex** O Female O Male

9 **Civil Status** O Single O Married O Widow/er O Separated O Live-in ☐ Annulled ☐ Divorced

6a **Informant** ☐ Self (Patient/Injured) ☐ Family member ☐ Police ☐ Others, specify _____ ☐ None

10 **Mother's Maiden Name** _____ (Last Name) _____ (First Name) _____ (Middle Name)

11 **Permanent Address** _____ (Number & Street Name) _____ (Region) _____ (Province) _____ (City/Municipality) _____ (Barangay) _____ (Zip Code)

12 **Landline #**

12a **Mobile #**

11a **Temporary Address** _____ (Number & Street Name) _____ (Region) _____ (Province) _____ (City/Municipality) _____ (Barangay) _____ (Zip Code)

12c **Email Address**

13 **Birth Date** ____/____/____ (mm dd yyyy)

14 **If Date of Birth is not available** _____Yrs ____ Mos ____ Days

15 **Place of Birth** (Province, City/Municipality)

16 **Religion**

17 **Nationality**

18 **Race**

19 **Ethnicity**

20 **Highest Educational Attainment**
☐ No formal education
☐ College Level/Graduate
☐ Elementary Level/Graduate
☐ High School Level/Graduate
☐ Vocational ☐ Post Graduate

21 **Occupation**
☐ Employed
☐ None/Unemployed
☐ Unknown
☐ Student
☐ Others, _____

22 **Company**

23 **PhilHealth #**

23a **Common Reference #**

24 **Contact Person** (*in case of emergency*) _____, _____, _____ (Last Name) (First Name) (Middle Name)

24b **Landline #**

24d **Email Address**

24a **Address** _____ (Number & Street Name) _____ (Region) _____ (Province) _____ (City/Municipality) _____ (Barangay) _____ (Zip Code)

24c **Mobile #**

INCIDENT INFORMATION

25 **Case/Incident No.:**

26 **External referral from:**
☐ DSWD _____ ☐ DOJ _____ ☐ NGO
☐ NBI _____ ☐ Relative ☐ Neighbor
☐ PNP _____ ☐ Others, specify _____
☐ Physician _____

27 **Handling Organization:** _____

28 **Address:** No. & Street: _____
Region: _____
Province: _____
Municipality/City: _____
Barangay _____ Zip Code _____

29 **Date of Intake:** __ __/ __ __ / _____ (mm dd yyyy)

30 **Intake By:** _____ (Last Name) _____ (First Name) _____ (Middle Name)

30a **Designation/Position:** _____

31 **VAWC Laws**
O RA 9262: Anti Violence against Women and Children Act
☐ Psychological ☐ Physical ☐ Others: _____
☐ Economic ☐ Sexual Abuse

O RA 8353: Anti – Rape Law of 1995
☐ Rape by sexual intercourse ☐ Rape by sexual assault

O RA 7877: Anti – Sexual Harassment Act

O RA 7610: Special Protection of Children Against Child Abuse, Exploitation and Discrimination Act

32 **Description of Incident:** _____

33 **Date of latest incident:** ____/____/____ (mm dd yyyy)
33a **Time:** _____ (military time to be entered)

34 **Date of Consultation:** ____/____/____ (mm dd yyyy)
34a **Time:** _____ (military time to be entered)

35 **Type of Abuse**
☐ Physical Abuse
☐ Sibling of Abused Child
☐ Neglect
☐ Sexual Abuse
☐ Unable to Validate Abuse
☐ Emotional/Psychological/Verbal Abuse
☐ Others, specify _____

36 **Type of Violence**
☐ Interpersonal Violence ☐ Child Maltreatment ☐ Elder Abuse ☐ Armed Violence ☐ Gang Violence ☐ Youth Violence
☐ Intimate Partner Violence ☐ Sexual Violence ☐ Violence related to Organized Crime ☐ Unable to Validate Abuses
☐ Others, specify _____

37 **Place of Incident:**
O Home
O Work
O School
O Commercial Places
O Religious Institutions
O Places of Medical Treatment
O Transport & Connecting Sites
O Unknown

38 **Geographic Location of Incident:**
Name of location: _____
(Name of school, office, clinic, church, establishments, terminals etc.)
No. & Street: _____
Region: _____

DEPARTMENT OF HEALTH
Violence Against Women and Children Registry Form

Annex 7.0

◯ Brothels and Similar Establishments ◯ Others _____	Province:_____ Municipality/City:_____ Barangay: _____ Zip code _____

39 **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:_____

40 **External Cause/s of Injury/ies:**

- ☐ Bites/stings, Specify animal/insect: _____
- ☐ Burns, __ Heat __ Fire __ Electricity __ Oil __ Friction __ Others, specify _____
- ☐ Chemical/substance, specify _____
- ☐ Contact with sharp objects, specify object _____
- ☐ Drowning: Type/Body of Water: __ Sea __ River __ Lake __ Pool __ Bath Tub __ Others: , specify: _____
- ☐ Fall , specify, from/in/on/into_____
- ☐ Sexual Assault/ Sexual Abuse/ Rape (Alleged)
- ☐ Others, specify _____
- ☐ Gunshot, specify weapon _____
- ☐ Hanging/Strangulation
- ☐ Mauling/Assault
- ☐ Transport /Vehicular Accident

HOSPITAL /FACILITY DATA:

41 **Transferred from another hospital/facility** ☐ Yes ☐ No

42 **Referred by another Hospital /Facility for Laboratory and/or other medical procedures** ☐ Yes ☐ No

43 **Name of Originating Hospital/Physician** : _____

44 **Status upon reaching Facility/Hospital:** ☐ Dead on Arrival ☐ Alive : If alive, please check if: ___ Conscious ___ Unconscious

45 **Mode of transport to the Hospital/Facility:** ☐ Ambulance ☐ Police vehicle ☐ Private vehicle ☐ Others, specify: _____

46 **Initial Impression:**

47 **ICD-10 Code/s: Nature of Injury :**	48**ICD-10 Code/s: External cause of Injury:**

49 **Treatment Given** : ☐ First Aid, specify: _____ ☐ Others, specify: _____
☐ Medico-Legal Exam ☐ Provision of appropriate medical treatment ☐ Issuance of Medical Certificate ☐ None

50 **Disposition**

- ☐ Admitted ☐ Treated and Sent Home ☐ Transferred to another facility/hospital, specify: _____
- ☐ HAMA ☐ Absconded
- ☐ Referred to Law Enforcement Date: __ __/ __ __/ _____ (mm dd yyyy) Type of Service:_____ Agency: _____
- ☐ Referred to Social Worker Date: __ __/ __ __/ _____ (mm dd yyyy) Type of Service:_____ Agency: _____
- ☐ Referred to Barangay Date: __ __/ __ __/ _____ (mm dd yyyy) Type of Service:_____ Agency: _____
- ☐ Referred to Other Service Provider Date: __ __/ __ __/ _____ (mm dd yyyy) Type of Service:_____ Name of Service Provider:_____

51 **Outcome** ☐ Improved ☐ Unimproved ☐ Died

B. IN-PATIENT (for admitted hospital cases only)

52 **Complete Final Diagnosis:** _____

53 **Disposition**

- ☐ Discharged ☐ Transferred to another facility/hospital, specify: _____ ☐ HAMA ☐ Absconded
- ☐ Referred to Law Enforcement Date: __ __/ __ __/ _____ (mm dd yyyy) Type of Service:_____ Agency: _____
- ☐ Referred to Social Worker Date: __ __/ __ __/ _____ (mm dd yyyy) Type of Service:_____ Agency: _____
- ☐ Referred to Barangay Date: __ __/ __ __/ _____ (mm dd yyyy) Type of Service:_____ Agency: _____
- ☐ Referred to Other Service Provider Date: __ __/ __ __/ _____ (mm dd yyyy) Type of Service:_____ Name of Service Provider:_____
- ☐ Others, specify; _____

54 **Outcome** ☐ Improved ☐ Unimproved ☐ Died

55 **ICD-10 Code/s: Nature of Injury :**	56 **ICD-10 Code/s: External cause of Injury:**

57 **If Transferred, Name of Health Facility**	58 **Reason for Transfer**

Annex 7.0

DEPARTMENT OF HEALTH
Violence Against Women and Children Registry Form

Perpetrator Information Sheet

PERPETRATOR

Perpetrator's Name: ______________ ______________ ______________
Last Name First Name Middle Name

Address: ______________ ______________ ______________ ______________ ______________ ______________
Number & Street Name Region Province City/Municipality Barangay Zip Code

Sex: ☐Female ☐Male **Age:**________
Nationality: __________ **Religion:**__________

Civil Status:
☐Single ☐Married
☐Live-in ☐Widowed
☐Separate

Identifying Marks:
____
____

Occupation:
☐ None/Unemployed ☐ Unknown
☐ Student ☐ Others, specify:__________

Relationship of the Perpetrator to victim:
○ Current spouse/partner
○ Former fiancé/dating relationship
○ Teacher/instructor/professor
○ Neighbors/peers/coworkers/classmates
○ Current fiancé/dating relationship
○ People of authority/service provider
○ Immediate family(e.g. father, mother __________)
○ Others relatives(e.g. uncle, cousin __________)
○ Others __________________
○ Former spouse/partner
○ Employer/manager/supervisor
○ Coach/trainer
○ Stranger
○ Agent of the employer

PERPETRATOR

Perpetrator's Name: ______________ ______________ ______________
Last Name First Name Middle Name

Address: ______________ ______________ ______________ ______________ ______________ ______________
Number & Street Name Region Province City/Municipality Barangay Zip Code

Sex: ☐Female ☐Male **Age:**________
Nationality: __________ **Religion:**__________

Civil Status:
☐Single ☐Married
☐Live-in ☐Widowed
☐Separate

Identifying Marks:
____
____

Occupation:
☐ None/Unemployed ☐ Unknown
☐ Student ☐ Others, specify:__________

Relationship of the Perpetrator to victim:
○ Current spouse/partner
○ Former fiancé/dating relationship
○ Teacher/instructor/professor
○ Neighbors/peers/coworkers/classmates
○ Current fiancé/dating relationship
○ People of authority/service provider
○ Immediate family(e.g. father, mother __________)
○ Others relatives(e.g. uncle, cousin __________)
○ Others __________________
○ Former spouse/partner
○ Employer/manager/supervisor
○ Coach/trainer
○ Stranger
○ Agent of the employer

PERPETRATOR

Perpetrator's Name: ______________ ______________ ______________
Last Name First Name Middle Name

Address: ______________ ______________ ______________ ______________ ______________ ______________
Number & Street Name Region Province City/Municipality Barangay Zip Code

Sex: ☐Female ☐Male **Age:**________
Nationality: __________ **Religion:**__________

Civil Status:
☐Single ☐Married
☐Live-in ☐Widowed
☐Separate

Identifying Marks:
____
____

Occupation:
☐ None/Unemployed ☐ Unknown
☐ Student ☐ Others, specify:__________

Relationship of the Perpetrator to victim:
○ Current spouse/partner
○ Former fiancé/dating relationship
○ Teacher/instructor/professor
○ Neighbors/peers/coworkers/classmates
○ Current fiancé/dating relationship
○ People of authority/service provider
○ Immediate family(e.g. father, mother __________)
○ Others relatives(e.g. uncle, cousin __________)
○ Others __________________
○ Former spouse/partner
○ Employer/manager/supervisor
○ Coach/trainer
○ Stranger
○ Agent of the employer

PERPETRATOR

Perpetrator's Name: ______________ ______________ ______________
Last Name First Name Middle Name

Address: ______________ ______________ ______________ ______________ ______________ ______________
Number & Street Name Region Province City/Municipality Barangay Zip Code

Sex: ☐Female ☐Male **Age:**________
Nationality: __________ **Religion:**__________

Civil Status:
☐Single ☐Married
☐Live-in ☐Widowed
☐Separate

Identifying Marks:
____
____

Occupation:
☐ None/Unemployed ☐ Unknown
☐ Student ☐ Others, specify:__________

Relationship of the Perpetrator to victim:
○ Current spouse/partner
○ Former fiancé/dating relationship
○ Teacher/instructor/professor
○ Neighbors/peers/coworkers/classmates
○ Current fiancé/dating relationship
○ People of authority/service provider
○ Immediate family(e.g. father, mother __________)
○ Others relatives(e.g. uncle, cousin __________)
○ Others __________________
○ Former spouse/partner
○ Employer/manager/supervisor
○ Coach/trainer
○ Stranger
○ Agent of the employer

Use another Perpetrator Information Sheet if needed

Instructions on how to fill-up the Violence Against Women and Children Registry Form

No.	Field Name	Instruction
1	**Registry No.**	This is a system-generated number assigned by the VAWC software. Once the VAWC report is encoded into the system, copy the system-generated number and write on this box.
2	**Name of Reporting Health Facility**	Write the name of the Hospital, Center or Clinic who is submitting the report.
3	**Hospital Patient ID No.**	Write the hospital-based issued I.D. or number to uniquely identify the patient.
4	**Hospital Registry No.**	Write the hospital-based issued I.D. or number to uniquely identify the patient.
5	**Hospital Case No.**	Write the hospital-based issued number to uniquely identify each case or incidence.
6	**Type of Patient**	Check the button for the corresponding type of patient the victim is.
6a	**Informant**	Check the appropriate box for the details on the informant, if the information were provided by the injured/abused then "Self" should be ticked or if no informant tick "None"
7	**Name of Patient**	Write the patient's Last name, First name and Middle name in the appropriate spaces provided. ***Note: Mr. X or None may be written if no informant can provide the information.***
8	**Sex**	Check the appropriate box for the sex of the injured/abused by birth.
9	**Civil Status**	Check the appropriate box for the civil status of the injured/ abused. Not legally separated still to be considered as "Married"
10	**Mother's Maiden Name**	Write the mother's name of the patient before marriage. The full middle name must be entered. If there is no middle name, write "N/A".
11	**Permanent Address**	Write the patient's permanent address - House No. and Street, Barangay, Municipality/City and Province
11a	**Temporary Address**	Write the patient's temporary address - House No. and Street, Barangay, Municipality/City and Province
12 12a-12b	**Landline #, Mobile #, Email Address**	Write the patient's contact details such as landline number, mobile number and email address.
13	**Birth Date**	Write the date of birth of the patient in the format mm/dd/yyyy (e.g. July 1, 1970 should be entered as 07/01/1970)
14	**If Date of Birth is not available**	If date of birth cannot be provided then enter in the space provided the age of the patient in years or months or days.
15	**Place of Birth**	Write the Province and the City/Municipality where the patient was born.
16	**Religion**	Write the patient's religion
17	**Nationality**	Write the patient's nationality
18	**Race**	Write the race of the person which describes the skin color, i.e. American (Red Skin), Caucasian (White Skin), Ethiopian (Black Skin), Malay (Brown Skin), Mongolian (Yellow Skin)
19	**Ethnicity**	Write the ethnicity of the patient, e.g. Asian, Indian, Pacific Islander, or others
20	**Highest Educational Attainment**	Write the highest educational attainment of the patient whether he is elementary, high school, vocational, college, post graduate, or others.
21	**Occupation**	Check the appropriate box for the occupation of the injured/abused.
22	**Company**	Write the name of the company where the injured/abused is working.
23	**PhilHealth #**	Write the PhilHealth Number if member or dependent.
23a	**Common Reference #**	Write the Unified Multi-Purpose ID Common Reference No. if the patient has any. (UMID CRN can be found in the upgraded, present government IDs such as the SSS, GSIS and Philippine Health Insurance Corp. UMID-CRN is the primary identifier of an individual transacting business or availing of services from any government agency.)
24 24a-24d	**Contact Person (in case of emergency) , Address, Landline #, Mobile #, Email Address**	Write the name of the person that may be contacted should any emergency may happen to the patient. Write the address and other contact details such as landline number, mobile number and the email address.
25	**Case/Incident No.**	Write the case/incident number.
26	**External Referral From**	Check the appropriate box for the referring agency.
27	**Handling Organization:**	Write the name of the organization who's handling the patient.
28	**Address:**	Write the address of the handling organization - House No. and Street, Region, Municipality/City, Province and Barangay.
29	**Date of Intake:**	Write the date of intake of the patient in the format mm/dd/yyyy (e.g. July 1, 1970 should be entered as 07/01/1970)
30	**Intake By:**	Write the intake personnel Last name, First name and Middle name in the appropriate boxes provided.
30a	**Designation/Position:**	Write the designation/position of the intake personnel.
31	**VAWC Laws:**	Check the appropriate box which VAWC laws described the incident of the patient.
32	**Description of Incident:**	Write the description/details of the incident.
33 33a	**Date of Latest Incident:** **Time:**	Write the date of occurrence of the latest incident in the format mm/dd/yyyy (e.g. July 1, 2007 should be entered as 07/01/2007.) Write the time of occurrence of the incident in military time (e.g. 8:00 am should be entered as 0800 hr and 8:00 pm as 2000 hr)

34 34a	**Date of Consultation:** **Time:**	Write the date of consult of the patient in the facility in the format mm/dd/yyyy (e.g. July 1, 2007 should be entered as 07/01/2007.) Write the time of consult of the patient in military time (e.g. 8:00 am should be entered as 0800 hr and 8:00 pm as 2000 hr)
35	**Type of Abuse:**	Check the appropriate box for specific type of abuse sustained by the patient.
36	**Type of Violence:**	Check the appropriate box for specific type of violence sustained by the patient.
37 38	**Place of Incident:** **Geographical Location of Incident:**	Check the appropriate box to indicate the place of incident whether it occurred at home, school (name of school), videoke bar, workplace or other specified place. Note: If the external cause occurred in places other than those specified then check "others" and indicate the specific place of occurrence (e.g. Mall, restaurant) Write the location or place where the injury/abuse occurred specifically the Street, Barangay, Municipality/City, Province and Region.
39	**Nature of Injury/ies:**	First, check the appropriate box to indicate whether it is a case of multiple injuries or not then check the appropriate box (es) for the specific injury (ies) sustained by the patient. For each type of injury selected or checked, the affected body location or site as well as other important details of the injury must also be written on the space provided opposite each type of injury.
40	**External Cause/s of Injury/ies:**	Check the appropriate box for the cause or mechanism of injury that is the way in which the person sustained the injury; how the person was injured/abused or the process by which the injury occurred. • **Bites/stings**: refer to poisonous or non-poisonous bite or sting through the skin. This includes human bite, dog bite, cat bite, snake bite, insect bite, stings from coral or jellyfish or bites and stings by other plants and animals. ***Note: If this is selected, the specific animal/insect/plant that caused the bite/sting must be indicated.*** • **Burns:** refer to the external causes such as heat, electricity, chemicals, light, radiation, and friction, severe exposure to flames or heat leading to damage in the skin or places deeper in the body. ***Note: If this is selected, check the appropriate box for the specific agent that caused the injury.*** • **Chemical/substances**: refer to exposure to chemicals / substances. This includes exposure, inhalation, ingestion and absorption of chemicals, drugs and other substances. However, this does not include harmful effects from normal therapeutic drugs (adverse effects). ***Note: If this is selected, the specific chemicals/substances that caused the injury must be indicated.*** • **Contact with sharp object**: External causes such as incision, slash, perforation, or puncture by a pointed or sharp instrument, weapon or object (e.g. knife, needle). • **Drowning**: refers to suffocation resulting from submersion in water or another liquid. ***Note: If this is selected, check the appropriate box for the specific type/body of water where the drowning occurred.*** • **Fall**: refers to the abrupt descent of a person due to the force of gravity and strikes a surface at the same or lower level. ***Note: If this is selected, information as to where the patient fall from/ in/ on into must be indicated (e.g. tree, manhole, escalator, stairs).*** • **Gunshot**: a penetrating force resulting from a bullet or other projectile shot from a powder-charged gun or pellet gun (e.g. Handguns, shotguns, rifles, pellet gun/rifle or pistol. ***Note: If this is selected, the specific type of weapon used must be indicated.*** • **Hanging/Strangulation**: refers to suspension of a person by a cord or anything used for tying. Also includes strangling with the hands, fingers, or other extremities and strangling with some form of cord or cloth such as rope, wire, or shoe laces, either partially or fully circumferencing the neck. • **Mauling/Assault**: is an act of violence by one or more persons where physical force or any means is used with the intent of causing harm, injury or death to another person. Does not include sexual assault, there is a separate box for sexual assault. • **Transport / Vehicular Accident**: an external cause of injury involving modes of transportation (land, air and water). ***Note: If this is selected, answers to section 15a are required.*** • **Sexual Assault/Sexual Abuse/Rape (Alleged):** an **assault** of a **sexual** nature on another person, or any **sexual** act committed without consent. • **Others**: refer to other external causes of injury that do not fit in any of the above categories (e.g. Operating machinery, foreign body, hit by falling objects, etc.). **Note:** If this is selected, the specific cause of injury must be indicated.
41	**Transferred from another hospital/facility**	Check the appropriate box to indicate whether the patient was transferred from another facility/hospital.
42	**Referred by another Hospital /Facility for Laboratory and/or other medical procedures**	Check the appropriate box to indicate whether the patient was referred by another hospital/ facility for laboratory and other medical procedures.
43	**Name of Originating Hospital/Physician**	Enter the name of the originating hospital or physician

44	**Status upon reaching Facility/Hospital**	Check the appropriate box to indicate the status of the patient upon reaching Hospital/facility. If "Alive" , check whether the injured was conscious or unconscious
45	**Mode of transport to the Hospital/Facility**	Check the appropriate box for the mode of transport of the injured/abused to the hospital or facility.
46	**Initial Impression**	Enter the initial impression on the patient's condition.
47	**ICD-10 Code/s: Nature of Injury :**	Enter the complete ICD-10 code (s) for the nature of injury following the ICD-10 coding rules and guidelines (Most of the codes should be within S00-T98). If there are multiple injuries, write the code for the multiple injuries first if there is any, unless a special coding rule applies, and followed by the codes for the individual injuries.
48	**ICD-10 Code/s: External cause of Injury:**	Enter the complete ICD-10 code (s) for the external cause of injury following the ICD-10 coding rules and guidelines (Codes should be within V01- Y36, Y85-Y87, and Y89). Place of occurrence and activity codes must also be provided if applicable. (Code (s) entered in Item No. 20 may just be copied here).
49	**Treatment Given**	Check whether any treatment was given to the injured in the ER/OPD/Referral. If "yes", write the specific treatment given.
50	**Disposition**	Check the appropriate box to indicate the status (disposition) of the patient at the time of release from ER/OPD/Referral or RHU. ***Note: If admitted, section B. IN-PATIENT must be filled up; otherwise there is no need to fill up said section. . If "transferred" , write the name of hospital/facility where the injured was transferred***
51	**Outcome**	Check the appropriate box to indicate the outcome of the patient's condition at the time of release from ER/OPD/Referral or RHU. If the outcome is either improved or unimproved then proceed to the next items, if the outcome is "died", skip to the item on Comments.
52	**Complete Final Diagnosis:**	Enter the complete final diagnosis of the patient.
53	**Disposition**	Check the appropriate box to indicate the status (disposition) of the patient at the time of Discharge.
54	**Outcome**	Check the appropriate box to indicate the outcome of the patient's condition at the time of discharge.
55	**ICD-10 Code/s: Nature of Injury :**	Enter the complete ICD-10 code (s) for the complete final diagnosis following the ICD- 10 coding rules and guidelines (Most of the codes should be within (S00-T98). If there are multiple injuries, write the code for the multiple injuries first if there is any, unless a special coding rule applies, and followed by the codes for the individual injuries.
56	**ICD-10 Code/s: External cause of Injury:**	Enter the complete ICD-10 code (s) for the external cause of injury following the ICD-10 coding rules and guidelines (Codes should be within V01- Y36, Y85-Y87, Y89). Place of occurrence and activity codes must also be provided if applicable. (Code (s) entered in Item No. 20 may just be copied here).
57	**If Transferred, name of facility:**	Enter the name for facility/hospital where the injured/abused was transferred.
58	**Reason for Transfer:**	Enter other reason (s) for transfer
59 59a 59b 59c 59d	**Consultant in-charge** **Address** **Landline #** **Mobile #** **Email Address**	The name, position title /designation of the Consultant in-charge must be entered on this portion including the address and contact details (landline no., mobile no. and email address).
60 60a 60b 60c 60d	**Completed By** **Address** **Landline #** **Mobile #** **Email Address**	The name, position title /designation of the personnel completing the form must be entered on this portion including the address and contact details (landline no., mobile no. and email address).
61	**Date Completed**	The date when the form was accomplished must be entered on this portion.

Instructions on how to fill-up the Perpetrator Information Sheet

Perpetrator's name:	Write the perpetrator's Last name, First name and Middle name in the space provided.
Address:	Write the perpetrator's address - House No. and Street, Region, Municipality/City, Province and Barangay.
Sex:	Check the appropriate box for the sex of the perpetrator by birth.
Age:	Write the age of the perpetrator.
Nationality:	Write the perpetrator's nationality.
Religion:	Write the religion of the perpetrator.
Civil Status:	Check the appropriate box for the civil status of the perpetrator. Not legally separated still to be considered as "Married"
Occupation:	Check the appropriate box for the occupation of the perpetrator, if employed please specify the details of employment.
Identifying Marks:	Write the identifying marks of the perpetrator (e.g. Tattoo on body parts, birth mark, scars etc.)
Relationship of the perpetrator to the victim:	Check the appropriate box for the relationship of the perpetrator to the victim. If others, please specify. **Note: Use another Perpetrator Information sheet if needed.**

Philippine Registry Form for Persons With Disability
Ver. 1.1

Place 1" X 1" Photo here

1. PWD NUMBER: | **2. DATE:**

3. LAST NAME: | **FIRST NAME:** | **MIDDLE NAME:**

4.TYPE OF DISABILITY:
- ◯ Psychosocial Disability
- ◯ Chronic Illness with Disability
- ◯ Learning Disability
- ◯ Mental Disability
- ◯ Visual Disability
- ◯ Orthopedic (Musculoskeletal) Disability
- ◯ Hearing Disability
- ◯ Speech Impairment
- ◯ Multiple Disabilities

5. CAUSES OF DISABILITY:
◯ Congenital/inborn ◯ Illness ◯ Acquired/accident.

6.ADDRESS:

House No. and Street	Barangay	Municipality	Province	Region

7. CONTACT DETAILS:

7a.TEL. NOS.:	7b.MOBILE NO.:	7c. EMAIL ADDRESS:

8.DATE OF BIRTH (*mm/dd/yyyy*):

9.SEX *(Please check one):*
◯ Male ◯ Female

10.CIVIL STATUS (Please check one) :
◯ Single ◯ Married ◯ Widow/er
◯ Separated ◯ Co-habitation (Live-in)

11.EDUCATIONAL ATTAINMENT *(Please check one):*
- ◯ Elementary Graduate
- ◯ Elementary Undergraduate
- ◯ High School Graduate
- ◯ High School Undergraduate
- ◯ College Graduate
- ◯ College Undergraduate
- ◯ Post Graduate
- ◯ Vocational
- ◯ None

12.EMPLOYMENT STATUS *(Please check one):* ◯ Employed ◯ Unemployed

13.NATURE OF EMPLOYER (*Please check one if employed):* ◯ Private ◯ Government

14.TYPE OF EMPLOYMENT (*Please check one if employed):*
◯ Contractual ◯ Permanent ◯ Self-Employed ◯ Seasonal

15. 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 Fishermen
- ◯ Trades and Related Workers
- ◯ Plant and Machine Operators and Assemblers
- ◯ Laborers
- ◯ Unskilled Workers
- ◯ Special Occupation
- ◯ Not Applicable

16. ID Reference No.

SSS No.:

GSIS No.:

Pag-ibig No.:

PhilHealth No:
- ◯ PhilHealth Member
- ◯ PhilHealth Member Dependent

17. BLOOD TYPE:
◯ A+ ◯ A- ◯ B+ ◯ B- ◯ AB+ ◯ AB- ◯ O+ ◯ O-

18.ORGANIZATION INFORMATION:

Organization Affiliated:	
Contact Person:	
Office Address:	
Tel. Nos.:	

19. PARENTAL INFORMATION:	Last Name	First Name	Middle Name
FATHER'S NAME:			
MOTHER'S NAME:			*(optional)*
GUARDIAN'S NAME:			
20. ACCOMPLISHED BY:			

20a.NAME OF REPORTING UNIT:	
21. REGISTRATION No.:	

Input Instruction Form

No.	Field Name	Instruction
1	**Registration No.**	This is a system-generated number assigned by the PRPWD software. Once the PWD report is encoded into the system, copy the system-generated number and write on this box.
2	**Date**	The date when the form was accomplished must be entered on this portion.
3	**Name of PWD**	Write the PWD's Last name, First name and Middle name in the appropriate spaces provided. ***Note: Mr. X or None may be written if no informant can provide the information.***
4	**Type of Disability**	Check the type of disability sustained by the PWD.
5-5c	**Address** **Telephone No.** **Mobile No.** **Email Address:**	Write the PWD's address - House No. and Street, Barangay, Municipality/City, Province, Region together with Tel no., Mobile no., and Email Address.
6	**Birth Date**	Write the date of birth of the PWD in the format mm/dd/yyyy (eg. July 1, 1970 should be entered as 07/01/1970) the birthday should not exceed in the current/registration date
7	**Sex**	Check the appropriate box for the sex of the PWD by birth.
8	**Nationality**	Write the PWD's nationality
9	**Civil Status**	Check the appropriate box for the civil status of the PWD. Not legally separated still to be considered as "Married"
10	**Educational Attainment**	Write the highest educational attainment of the PWD whether he is elementary, high school, vocational, college, post graduate, or others.
11	**Employment Status**	Check the appropriate employment status of the PWD.
12	**Nature of Employer**	Check the appropriate nature of employer of the PWD.
13	**Type of Employment**	Check the appropriate type of employment of the PWD.
14	**Type of Skills**	Check the appropriate type of skills of the PWD.
15	**SSS No.** **GSIS No.** **PHILHEALTH No.**	Write the **SSS, GSIS and Philippine Health Insurance Number,** if the PWD has PHILHEATH Number, check if the patient is a member or a member dependent.
16	**Organizational Information**	Write the organizational information of the PWD including the Name of Organization, Affiliated, Contact Person, Office Address, and Telephone Nos. If NONE, leave it blank.
17	**Parental Information:** **Father's Name:** **Mother's Name:** **Guardian's Name:**	Write the PWD's Parental Information such as Father, Mother and Guardian Last name, First name and Middle name in the appropriate spaces provided.
18	**Accomplished by:**	Personnel completing the form must be entered on this portion
18a	**Name of Reporting Unit:**	For issuing office only

Annex 9.0 Incident Report

Incident Report Form

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

Building 1, San Lazaro Compound, Rizal Avenue, Sta. Cruz, 1003 Manila • Trunk Line 651-7800 Direct Line: 711-9501
Fax: 743-1829; 743-1786 • URL: http://www.doh.gov.ph; e-mail: osec@doh.gov.ph