DEFENCE HEALTH MAINTENANCE LTD.

Name of Hospital/clinic_____ HCP Code_____

Location: _____ **MONTHLY ENCOUNTER SHEET**

Month_____

No. of visits during the month_____

S/No.	Date	Name of Patient	Age	Sex	NHIS No	Diagnosis	Treatment	Patient's Sign

TREATMENT CODES

A – Admission

R – Referred

OP – Out Patient

Please use additional sheets if necessary

Prepared by: _____

Medical Director's Signature_____