NATIONAL HEALTH INSURANCE SCHEME

Consultation Experience Data Form

Name of Primary Health Care Provider _____HMO Code: _____

Programme_____

Month/Year: _____

Summary of Patient Visit

Date	*Name*	*SVC No./ NHIS No.*	*Age*	*Gender (M/F)*	*Diagnosis/Complaint*	*Repeat Visit (Y/N)*	*Treatment/ Prescription*	*Sign*	*Treatment Cost*	*Referral Visit (Y/N)*	*Reason(s) for Referral*	*If Referred FFS Cost*

Programme- Formal Sector Social Health Insurance Programme(FSSHIP)

Name of Data Collection Staff_____

Signature & Date_____