

NATIONAL HEALTH INSURANCE SCHEME

Consultation Experience Data Form

	Programme											
	Month/Year: _											
					Summe	ary of P	atient 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
	J				urance Programme(FS	·						
	Name of Data Collection StaffSignature & Date											