# TOTAL HEALTH TRUST LTD.
## (HMO)

## ENCOUNTER DOCUMENTATION

PROVIDER _____

PROVIDER CODE _____ MONTH _____

| DATE | NAME | THT NUMBER | DIAGNOSIS | TREATMENT | REFERRAL | HOSPITALISATION | PATIENT'S SIGNATURE | DOCTOR |
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_____ COLLETING OFFICER (NAME)

_____ SIG. & DATE COLLECTED

_____ MEDICAL DIRECTOR