Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "C1.3 – Cervical CA"

HEALTHCARE *PROVIDER (HCP)*		
ADDRESS OF *HCP*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	*SEX* ☐ *Male* ☐ *Female*
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	☐ *Same as patient* *(Answer the following only if the patient is a dependent)* 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF MANDATORY and OTHER SERVICES
Chemoradiation with Linear Accelerator and Brachytherapy (Low/High Dose) for Cervical Cancer

Place a (✓) in the appropriate tick box if *the service is* done *or* given

MANDATORY SERVICES	OTHER SERVICES as needed/ as indicated
Preoperative Laboratory:	
☐ CBC	☐ Partial thromboplastin time
☐ Platelet count	☐ CT scan or MRI
☐ Blood typing	☐ Blood support (screening, processing)
☐ Chest X-ray	☐ Cystoscopy
☐ ECG	☐ Proctosigmoidoscopy
☐ FBS	
☐ Na, K, Cl, Ca	
☐ Creatinine	
☐ AST/ALT	
☐ Pro-time	
☐ Urinalysis	
☐ Histopathology	
☐ TV-UTZ	
	☐ Blood Transfusion Support
Radiation Treatment Summary a. Pelvic radiation ☐ Linear Accelerator b. Brachytherapy (tick one of the following) ☐ Low dose rate ☐ High dose rate	**Date of Procedure** (start mm/dd/yyyy –end mm/dd/yyyy): _____ **Dates of Procedure** (mm/dd/yyyy): _____ _____ _____ _____

MANDATORY SERVICES

Chemotherapy medications (Check only one chemotherapy per cycle)

Cycle	Cisplatin	Carboplatin	Others: (specify)	Remarks
I				
II				
III				
IV				
V				
VI				

Chemotherapy Treatment Summary

Cycle	Date (mm/dd/yyyy)	Remarks
I		
II		
III		
IV		
V		
VI		

OTHER SERVICES

Pre chemotherapy laboratory exams per cycle

Cycle	CBC	Creatinine	Mg	Urinalysis
I				
II				
III				
IV				
V				
VI				

Support medications

Cycle	Anti-emetics	G-CSF	Hematinics	Others: specify
I				
II				
III				
IV				
V				
VI				

Post treatment Medications (home medications)

Cycle	Anti-emetics	Analgesics	Hematinics	Others: specify
I				
II				
III				
IV				
V				
VI				

HEALTHCARE *PROVIDER (HCP)*		
ADDRESS OF *HCP*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	☐ *Same as patient* *(Answer the following only if the patient is a dependent)* 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

Certified correct by:	Certified correct by:
(Printed name and signature) Gynecologic Oncologist	(Printed name and signature) Radiation Oncologist
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:	Certified correct by:
(Printed name and signature) Patient	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
Date signed (mm/dd/yyyy)	PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐
	Date signed (mm/dd/yyyy)