



Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION

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Call Center (02) 441-7442 Trunkline (02) 441-7444
www.philhealth.gov.ph



Case No. _____

Annex "C1.2- Rectum CA"

CHECKLIST OF MANDATORY AND OTHER SERVICES

Rectum cancer pre-operative clinical stage I with post-operative pathologic stage II - III

Tranche 1 of 3

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>

Specify the following:

Clinical stage prior to initiation of treatment	cT:	N:	M:
Pathologic stage	pT:	N:	M:

Place a (✓) if DONE or NA if not applicable in the status column.

MANDATORY AND OTHER SERVICES	Status
Procedure:	
1. Colonoscopy	
2. Proctoscopy	
3. Histopathology	
4. Surgery (definitive)	
5. Surgery for closure of colostomy/ileostomy, if needed	
Diagnostics:	
6. Pelvic MRI or endorectal ultrasound	
7. CT scan of whole abdomen (preferably, triple contrast)	
8. Fasting blood sugar (FBS)	
9. Carcinoembryonic antigen (CEA), as baseline	
10. Complete blood count	
11. Blood typing	
12. Albumin	
13. Creatinine	

MANDATORY AND OTHER SERVICES	Status
14. Chest x-ray (PA-L)	
15. Chest CT, as needed	
16. ECG, as needed	
17. CP clearance, as needed	
18. SGPT, as needed	
19. Prothrombin time, as needed	
20. Alkaline phosphatase, as needed	
21. Bilirubin, as needed	
22. CEA for monitoring, as needed	
23. SGPT for monitoring, as needed	
24. Creatinine for monitoring, as needed	
25. 2D echocardiogram, as needed	
Medicines, as indicated	
1. Antibiotics, specify	
2. Pain relievers, specify	
Others: Blood support, as needed	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>	PhilHealth Accreditation No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Certified correct by:	Conforme by:
(Printed name and signature) Attending Radiation Oncologist	(Printed name and signature) Patient
PhilHealth Accreditation No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	