*Republic of the Philippines*
**PHILIPPINE HEALTH INSURANCE CORPORATION**
Citystate Centre Building, 709 Shaw Boulevard, Pasig City
Healthline 441-7444 www.philhealth.gov.ph

Date _____Date Admitted : _____

Name of Hospital _____ Date Discharged: _____

Name of Patient _____

PhilHealth ID Number _____

**STANDARD RISK ELECTIVE**
**CORONARY ARTERY BYPASS GRAFT SURGERY (CABG)**
**CHECKLIST OF MANDATORY and OTHER SERVICES**

| **MANDATORY SERVICES** | **Confirmed done / Date signed** |
|---|---|
| I. Preoperative Laboratory tests such as :<br>• CBC<br>• Platelet count<br>• Blood typing<br>• Na<br>• K<br>• Mg<br>• Calcium<br>• FBS<br>• BUN<br>• Creatinine<br>• Chest XRay (PA/lateral)<br>• 12-LEAD ECG<br>• Room air ABG<br>• Protime-INR<br>• Plasma thromboplastin time | _____<br>Name & Signature of Cardiologist |
| II. Medications<br>• BetaBlocker<br>• Statin<br>• ACE inhibitor or ARB<br>• ASA<br>• Preoperative Antibiotic Prophylaxis | _____<br>Name & Signature of Cardiologist |
| III. Blood bank screening and blood products as indicated | _____<br>Authorized Blood Bank Staff |

| | |
|---|---|
| IV. Open Heart Surgery under General Anesthesia | _____<br>Cardiovascular Surgeon<br><br>_____<br>Anesthesiologist |
| V. Immediate Postoperative Care at Surgical ICU | _____<br>Cardiologist |
| VI. Continuing Postoperative Care at Regular room | _____<br>Cardiologist |
| VII. Cardiac Rehabilitation | _____<br>Authorized Cardiac Rehab Staff |

| **OTHER SERVICES** | **Confirmed done by Cardiologist /Date signed** |
|---|---|
| 1. Additional laboratory tests as needed e.g. CBC, Platelet count, APTT, PTPA-INR, FBS, Na, K, Mg, Calcium, BUN, Creatinine, TPAG, ABG, Urinalysis | |
| 2. Additional Chest x-ray (portable/AP/lateral), 12-lead ECG, 2DED, TEE, as indicated | |
| 3. Ankle-brachial index, carotid duplex scan as indicated | |
| 4. Postoperative antibiotics if indicated (IV and oral) | |
| 5. Treatments as indicated<br>a. Incentive spirometry<br>b. VTE Prophylaxis with compression stockings/ intermittent pneumatic compression/ intravenous/subcutaneous heparin, LMWH, fondaparinux<br>c. Nebulization with medications such as beta agonist + steroid or salbutamol/pulmonary physiotherapy<br>d. Blood glucose monitoring | |

| | |
|---|---|
| e. Wound dressings/wound care | |
| 6. Other medications, as indicated, such as: clopidogrel, digoxin, furosemide IV or oral, amiodarone, vasopressors (dopamine, levophed, epinephrine infusion drip), inotropic drugs (dobutamine infusion drip),vasodilator (NTG or Isoket or Nicardipine), insulin regimen, oral hypoglycemic drugs, proton pump inhibitor/antacid, pain relievers/analgesics, sedatives/anxiolytics, magnesium chloride, calcium gluconate, potassium chloride, lactulose/stool softeners | |
| 7. Pulmonary care, as indicated, such as ventilator support; nebulization, with beta 2 agonist/ combination with steroid | |
| 8. Other specialty services as needed, such as pulmonology, nephrology, neurology, infectious disease, etc. | |

CONFORME BY PATIENT:

_____
Printed Name and Signature

## STANDARD RISK ELECTIVE
## CORONARY ARTERY BYPASS GRAFT SURGERY (CABG)

Name: _____ Age: ____Sex ____ PhilHealth No. _____
Address: _____ Date of Birth:_____
_____
Date of Admission: _____
Date of Discharge: _____ :

TRANCHE 1 REQUIREMENTS CHECKLIST

| **I. First Tranche Payment** | Please Check |
|---|---|
| 1. Copy of Completely Accomplished ME FORM | |
| 2. Completed Philhealth FORMS 1 AND 2 | |
| 3. Completed Z Satisfaction Questionnaire | |
| 4. Copy of Approved Pre –Authorization Checklist & Request | |
| 5. Completed Pre-claims Assessment of Services Checklist | |
| 6. Accomplished Surgical Operative Report | |
| 7. Accomplished Anaesthesia Report | |
| 8. Discharge Summary Signed by Attending Physician | |
| DATE COMPLETED :<br>DATE FILED : | |

Attested by:

_____ _____
Printed Name & Signature Printed Name & Signature
Attending Physician Executive Director/Medical Center Chief

CONFORME BY PATIENT:

_____
Printed Name and Signature

## STANDARD RISK ELECTIVE
## CORONARY ARTERY BYPASS GRAFT SURGERY (CABG)

Name: _____ Age: ____Sex ____ PhilHealth No. _____
Address: _____ Date of Birth: _____
_____
Date of Admission: _____
Date of Discharge: _____ :

TRANCHE 2 REQUIREMENTS CHECKLIST

| **II. Second Tranche Payment** | Please check |
|---|---|
| 1. Completed Cardiac Rehab Form | |
| 2 Completed Certificate of OPD Follow-up consultation | |
| DATE COMPLETED :<br>DATE FILED : | |

Attested by:

_____ _____
Printed Name & Signature Printed Name & Signature
Attending Physician Executive Director/Medical Center Chief

CONFORME BY PATIENT

_____
Printed Name and Signature