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 _____

CHECKLIST OF MANDATORY and OTHER SERVICES
SURGERY FOR CERVICAL CANCER STAGE IA1 – II A1

TRANCHE 1
(Place a ✓ and indicate status or date done or given)

SERVICES 1st Tranche Surgery for Cervical CA Stage IA1-IIA1	Check and Indicate Date Done/ Given	Physician's Name and Signature	Conforme (patient's signature)
1. Preoperative Laboratory * a. CBC b. Platelet count c. Blood typing d. Chest X-ray e. ECG f. FBS g. Na, K, Cl, Ca h. Creatinine i. AST/ALT j. Pro-time k. Partial Thromboplastin Time l. Urinalysis m. Histopathology n. Imaging: n.1. TV-UTZ n.2. CT Scan or MRI o. Blood support, screening, processing *p.* Cystoscopy *q.* Proctosigmoidoscopy **if needed/ if done*	☐ **a.**_____ ☐ **b.**_____ ☐ **c.**_____ ☐ **d.** _____ ☐ **e**_____ ☐ **f.** _____ ☐ **g.**_____ ☐ **h.** _____ ☐ **i.**_____ ☐ **j.** _____ ☐ **k.**_____ ☐ **l.**_____ ☐ **m.**_____ ☐ **n.**_____ ☐ **o.**_____ ☐ **p.**_____ ☐ **q.**_____		
2. Preoperative antibiotic Prophylaxis: a. Cefuroxime b. Cefoxitin c. Other antibiotics	☐ **a.** _____ ☐ **b.** _____ ☐ **c.** _____		

SERVICES 1st Tranche Surgery for Cervical CA Stage IA1-IIA1	Check and Indicate Date Done/ Given	Physician's Name and Signature	Conforme (patient's signature)
3. Procedure done **For Stage IA1 alone:** Extrafascial/Total Hysterectomy with or without bilateral salpingoophorectomy **For stage 1A2 -1B1**: Radical Hysterectomy with bilateral pelvic lymphadenectomy, paraortic lymph node sampling ☐ Bilateral salpingoophorectomy ☐ transposition of ovaries	Date of Procedure : _____	Gynecologic Oncologist : _____	
4. Blood Transfusion Support (if indicated) ☐FWB ☐PRBC ☐FFP	☐ _____		
5. Postoperative Laboratory : (when indicated, if done) a. CBC with platelet b. ECG c. electrolytes	Check if applicable and place date or NA ☐ a._____ ☐ b. _____ ☐ c._____		
6. Postoperative Medications (as indicated, when needed) a. Analgesics b. Antibiotics c. Hematinics	Check if applicable and place Status/date or NA ☐ a._____ ☐ b. _____ ☐ c. _____		
7. Completed and Signed Z Satisfaction Questionnaire	☐ _____		
8. Operative Record	☐ _____		

Attested by: **Date:** _____

_____
Name and Signature of Medical Director

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TRANCHE 2

(Place a ✓ and indicate status or Date done or Given)

Documents for 2nd Tranche Surgery for Cervical CA Stage IA1-IIA1	Please check if applicable and indicate date	Name & Signature of Gynecologic Oncologist	Conforme (Signature of Patient)
1. Medical Certificate of the out-patient follow up consultation (within 2 weeks post-op) with written request for outpatient pap smear 3 months from surgery	☐ _____		
2. Histopathology Result (definitive surgery)	☐ _____		

Attested by:

_____
Name and Signature of Medical Director

Date: _____