



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 _____

**VENTRICULAR SEPTAL DEFECT
CHECKLIST OF MANDATORY and OTHER SERVICES**

TRANCHE I

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

SERVICES FIRST TRANCHE	Check and Indicate Date Done/ Given	Attested by: (Name & Signature of Attending Physician)
1. Preoperative Laboratory a. CBC with platelet with Blood typing b. Chest X-ray c. Na, K, Cl, Ca d. Creatinine e. Protime f. Partial Thromboplastin Time	<input type="checkbox"/> A. _____ <input type="checkbox"/> B. _____ <input type="checkbox"/> C. _____ <input type="checkbox"/> D. _____ <input type="checkbox"/> E. _____ <input type="checkbox"/> F. _____	
2. Preoperative IE Prophylaxis: a. Vancomycin b. Amikacin	<input type="checkbox"/> _____ <input type="checkbox"/> _____	
3. Procedure done (D3) VSD Patch Closure	RVS code: _____ Date of Procedure : _____	Pedia TCV Surgeon : _____ CV Anesthesiologist : _____ Pedia Cardiologist : _____



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<p>4. Anaesthesia (Check or NA if not applicable)</p> <p>a. Sevoflorane b. Fentanyl c. Midazolam d. Atropine e. Ketamine f. Esmeron g. Dexamethasone h. Calcium gluconate i. Sodium bicarbonate j. Potassium Chloride k. Magnesium Sulfate l. Heparin m. Protamine sulphate n. Dopamine o. Dobutamine p. Nitroglycerine q. Milrinone</p>	<p>Check if applicable and place Status/date or indicate NA</p> <p><input type="checkbox"/> A. _____ <input type="checkbox"/> B. _____ <input type="checkbox"/> C. _____ <input type="checkbox"/> D. _____ – <input type="checkbox"/> E. _____ <input type="checkbox"/> F. _____ <input type="checkbox"/> G. _____ – <input type="checkbox"/> H. _____ <input type="checkbox"/> I. _____ <input type="checkbox"/> J. _____ <input type="checkbox"/> K. _____ <input type="checkbox"/> L. _____ <input type="checkbox"/> M. _____ <input type="checkbox"/> N. _____ <input type="checkbox"/> O. _____ <input type="checkbox"/> P. _____ <input type="checkbox"/> Q. _____</p>	<p style="text-align: center;">CV Anesthesiologist :</p> <p style="text-align: center;">_____</p>
<p>5. Intraoperative Transesophageal Echo or Transthoracic echo within 48 hours postop (Attach Result)</p>	<p><input type="checkbox"/> _____</p>	
<p>6. Blood Transfusion Support (if applicable) <input type="checkbox"/> FWB <input type="checkbox"/> PRBC <input type="checkbox"/> FFP</p>	<p><input type="checkbox"/> _____</p>	
<p>7. Ventilatory support at least 6 hours</p>	<p><input type="checkbox"/> _____</p>	



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<p>8. Postoperative Laboratory:</p> <p>8.1. 1st 6 Hours postop</p> <p>a. CBC with platelet</p> <p>b. Chest Xray (portable)</p> <p>c. PT</p> <p>d. PTPA</p> <p>e. Na, K, Ca</p> <p>f. ABG's</p> <p>8.2. Postop 5th-7th day (Pre-discharge):</p> <p>a. CBC</p> <p>b. Chest Xray (PAL)</p>	<p><input type="checkbox"/> A. _____</p> <p><input type="checkbox"/> B. _____</p> <p><input type="checkbox"/> C. _____</p> <p><input type="checkbox"/> D. _____</p> <p><input type="checkbox"/> E. _____</p> <p><input type="checkbox"/> F. _____</p> <p><input type="checkbox"/> A. _____</p> <p><input type="checkbox"/> B. _____</p>	
<p>9. Postoperative Medications</p> <p>a. Dopamine</p> <p>b. Dobutamine</p> <p>c. Nitroglycerine drip</p> <p>d. Milrinone</p> <p>e. Calcium Gluconate</p> <p>f. Tramadol</p> <p>g. Midazolam (sedation)</p> <p>h. Ranitidine</p> <p>i. Oral Digoxin</p> <p>j. Oral Furosemide</p> <p>k. Oral Captopril</p> <p>l. Oral Paracetamol or Ibuprofen</p>	<p>Check if applicable and place Status/date or NA</p> <p><input type="checkbox"/> A. _____</p> <p><input type="checkbox"/> B. _____</p> <p><input type="checkbox"/> C. _____</p> <p><input type="checkbox"/> D. _____</p> <p><input type="checkbox"/> E. _____</p> <p><input type="checkbox"/> F. _____</p> <p><input type="checkbox"/> G. _____</p> <p><input type="checkbox"/> H. _____</p> <p><input type="checkbox"/> I. _____</p> <p><input type="checkbox"/> J. _____</p> <p><input type="checkbox"/> K. _____</p> <p><input type="checkbox"/> L. _____</p>	

CONFORME :

Parent/Legal Guardian of Patient
Printed Name and Signature

Relation to Patient : _____

Documents Reviewed by:

Printed Name & Signature
PHILHEALTH Z MANAGER

Attested by:

Name and Signature of Attending Physician

Name and Signature of Executive Director/
Medical Center Chief

VENTRICULAR SEPTAL DEFECT TRANCHE I