



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: _____

Date Discharged: _____

Name of Hospital _____

Name of Patient _____

PhilHealth ID Number _____

**CHECKLIST OF MANDATORY and OTHER SERVICES
 CHEMOTHERAPY, BRACHYTHERAPY (LOW DOSE) WITH COBALT
 CERVICAL CANCER**

TRANCHE 1

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

SERVICES 1 ST TRANCHE (Chemo, Low Dose Brachy, Cobalt)	Check and Indicate Date Done/ Given	Physician's Name & Signature	Conforme (Patient's Signature)
1. Pre-procedure 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. Protime 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 <i>*if needed/ if done</i>	<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. _____		



Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION

Citystate Centre Building, 709 Shaw Boulevard, Pasig City
 Healthline 441-7444 www.philhealth.gov.ph



Bawat Pilipino **MIYEMBRO**
 Bawat miyembro **PROTEKTADO**
 Katatagan natin **SEGUADO**

SERVICES 1st TRANCHE (Chemo, Low Dose Brachy, Cobalt)	Check and Indicate Date Done/ Given	Physician's Name & Signature	Conforme (Patient's Signature)
<p>2. Radiation Therapy</p> <p>A. Pelvic Radiation <input type="checkbox"/> Pelvic Cobalt</p> <p>B. Brachytherapy <input type="checkbox"/> Low dose rate</p>	<p>Dates of Procedure (start mm/dd/yy – end mm/dd/yy):</p> <p>_____</p> <p>Dates of Procedures mm/dd/yy</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Gynecologic Oncologist : _____</p> <p>Radiation Oncologist :</p> <p>_____</p> <p>Gynecologic Oncologist : _____</p> <p>Radiation Oncologist :</p> <p>_____</p>	
<p>3. Chemotherapy</p> <p>A. Pre chemotherapy laboratory exams*</p> <ol style="list-style-type: none"> 1. CBC 2. Creatinine 3. Mg 4. Urinalysis <p>*if indicated and done</p> <p>B. Chemotherapy Medications</p> <input type="checkbox"/> 1. Cisplatin <input type="checkbox"/> 2. Carboplatin <input type="checkbox"/> 3. Others _____ <p>C. Support medications</p> <input type="checkbox"/> 1. Anti emetics Ramosetron Granisetron Metoclopramide <input type="checkbox"/> 2. G-CSF <input type="checkbox"/> 3. Hematinics <input type="checkbox"/> 4. Others _____	<p>Indicate dates done and cycle number I,II,III,IV,V,VI (mm/dd/yy)</p> <p><input type="checkbox"/> 1. _____</p> <p><input type="checkbox"/> 2. _____</p> <p><input type="checkbox"/> 3. _____</p> <p><input type="checkbox"/> 4. _____</p> <p>Indicate cycle number I,II,III,IV,V,VI and date (mm/dd/yy)</p> <p>_____</p> <p>_____</p> <p>Indicate dates given and cycle number I,II,III,IV,V,VI (mm/dd/yy)</p> <p><input type="checkbox"/> 1. _____</p> <p><input type="checkbox"/> 2. _____</p> <p><input type="checkbox"/> 3. _____</p> <p><input type="checkbox"/> 4. _____</p>	<p>Gynecologic Oncologist : _____</p>	



Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION

Citystate Centre Building, 709 Shaw Boulevard, Pasig City
 Healthline 441-7444 www.philhealth.gov.ph



SERVICES 1st TRANCHE (Chemo, Low Dose Brachy, Cobalt)	Check and Indicate Date Done/ Given	Physician's Name & Signature	Conforme (Patient's Signature)
4. Blood Transfusion Support (if indicated) <input type="checkbox"/> FWB <input type="checkbox"/> PRBC <input type="checkbox"/> FFP	<input type="checkbox"/> _____		
5. Post treatment Medications (home medications, if indicated) a. Anti emetics b. Analgesics c. Hematinics d. Others	Check if applicable and place Status/date or NA <input type="checkbox"/> a. _____ <input type="checkbox"/> b. _____ <input type="checkbox"/> c. _____ <input type="checkbox"/> d. _____		
6. Completed and Signed Z Satisfaction Questionnaire	<input type="checkbox"/> _____		
7. Radiation Treatment Summary A. Pelvic Radiation (cobalt) B. Brachytherapy (low dose)	<input type="checkbox"/> A. _____ <input type="checkbox"/> B. _____	Radiation Oncologist: _____	
8. Chemotherapy Treatment Summary and indicate no. of cycles completed I,II,III,IV,V,VI (at least 3 completed cycles)	<input type="checkbox"/> I _____ <input type="checkbox"/> II _____ <input type="checkbox"/> III _____ <input type="checkbox"/> IV _____ <input type="checkbox"/> V _____ <input type="checkbox"/> VI _____	Gynecologic Oncologist: _____	

Attested by:

Name and Signature of Medical Director

Date: _____



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
 CHEMOTHERAPY, BRACHYTHERAPY (LOW DOSE) WITH COBALT
 CERVICAL CANCER**

TRANCHE 2

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

DOCUMENT 2ND TRANCHE	Please check if applicable and indicate date	Name & Signature of Gynecologic Oncologist	Conforme (Patient's Signature)
1. Medical Certificate of Out-Patient Follow up Consultation (Within 2 weeks post-procedure) with written request for out-patient pap smear 3 months post-procedure	<input type="checkbox"/> _____		

Attested by:

Name and Signature of Medical Director

Date: _____