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, HIGH DOSE BRACHYTHERAPY AND LINEAR ACCELERATOR FOR CERVICAL CANCER TRANCHE 1

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

SERVICES 1st TRANCHE (Chemorad + Linear Accelerator)	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 **if needed/ if done*	☐ **a.**_____ ☐ **b.**_____ ☐ **c.**_____ ☐ **d.** _____ ☐ **e** _____ ☐ **f.** _____ ☐ **g.**_____ ☐ **h.** _____ ☐ **i.**_____ ☐ **j.** _____ ☐ **k.**_____ ☐ **l.**_____ ☐ **m.**_____ ☐ **n.**_____ ☐ **o.**_____ ☐ **p.**_____ ☐ **q.**_____		

SERVICES 1st TRANCHE (Chemorad + Linear Accelerator)	Check and Indicate Date Done/ Given	Physician's Name & Signature	Conforme (Patient's Signature)
2. Radiation Therapy 1. Pelvic Radiation ☐ Linear Accelerator 2. Brachytherapy ☐ High dose rate	**Dates of Procedure (start mm/dd/yy – end mm/dd/yy):** _____ **Dates of Procedures mm/dd/yy** _____ _____ _____ _____	Gynecologic Oncologist :_____ Radiation Oncologist : _____ Gynecologic Oncologist :_____ Radiation Oncologist : _____	
3. Chemotherapy A. Pre chemotherapy laboratory exams* 1. CBC 2. Creatinine 3. Mg 4. Urinalysis *when indicated, if done B. Chemotherapy Medications ☐ 1. Cisplatin ☐ 2. Carboplatin ☐ 3. Others_____ C. Support medications* ☐ 1. Anti emetics Ramosetron Granisetron Metoclopramide ☐ 2. G-CSF ☐ 3. Hematinics ☐ 4. Others_____ *when indicated	**Indicate dates done and cycle number I,II,III,IV,V,VI (mm/dd/yy)** ☐ **1.**_____ ☐ **2.**_____ ☐ **3.**_____ ☐ **4.**_____ **Indicate cycle number I,II,III,IV,V,VI and date (mm/dd/yy)** _____ _____ **Indicate dates given and cycle number I,II,III,IV,V,VI (mm/dd/yy)** ☐ **1.**_____ ☐ **2.**_____ ☐ **3.**_____ ☐ **4.**_____	Gynecologic Oncologist :_____	

SERVICES 1st TRANCHE (Chemorad + Linear Accelerator)	Check and Indicate Date Done/ Given	Physician's Name & Signature	Conforme (Patient's Signature)
4. Blood Transfusion Support (if indicated) ☐FWB ☐PRBC ☐FFP	☐ _____		
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** ☐ **a.**_____ ☐ **b.** _____ ☐ **c.** _____ ☐ **d.**_____		
6. Completed and Signed Z Satisfaction Questionnaire	☐ _____		
7. Radiation Treatment Summary A. Pelvic Radiation (linear accelerator) B. Brachytherapy (high dose)	☐ **A.**_____ ☐ **B.** _____	Radiation Oncologist: _____	
8. Chemotherapy Treatment Summary and indicate no. of cycles completed I,II,III,IV,V,VI (at least 3 completed cycles) *when indicated	☐ **I**_____ ☐ **II**_____ ☐ **III**_____ ☐ **IV**_____ ☐ **V**_____ ☐ **VI**_____	Gynecologic Oncologist: _____	

Attested by:

_____
Name and Signature of Medical Director

Date: _____

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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)
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	☐ _____		

Attested by:

_____
Name and Signature of Medical Director

Date: _____