



**PHILHEALTH CIRCULAR**  
 No. 2016-0030

**TO : ALL PHILHEALTH MEMBERS, ACCREDITED LEVELS 1, 2 AND 3 GOVERNMENT HOSPITALS, DOH LICENSED/CERTIFIED DRUG ABUSE TREATMENT AND REHABILITATION CENTERS PHILHEALTH REGIONAL OFFICES AND ALL OTHERS CONCERNED**

**SUBJECT : Medical Detoxification Package**

**I. BACKGROUND AND RATIONALE**

One of the major thrusts of the Philippine Health Agenda 2016-2022 is to address the triple burden of disease of which substance abuse is included in the top 20% of the most burdensome diseases of the country. The World Health Organization refers to substance abuse as the “harmful or hazardous use of psychoactive substances.”

Recent estimates by the Dangerous Drugs Board show that there are 1.8 million drug users in the Philippines, of which the majority or 91% of drug use is methamphetamine. It is a highly addictive stimulant drug that leads to a chronic and relapsing disease caused by chemical and molecular changes in the brain resulting to severe structural and functional damage in areas associated with memory and emotion.

The Philippine Health Insurance Corporation (PhilHealth), in its mandate to provide health insurance coverage for all Filipinos, supports the current government’s efforts in the fight against drugs and is one with other agencies’ goal in the achievement of long term abstinence from the use of illicit substances.

Pursuant to PhilHealth Board Resolution No. 2159, s. 2016, PhilHealth shall ensure the provision of the minimum standards of medical interventions to safely manage the acute physical symptoms of withdrawal associated with stopping drug use through a medical detoxification package.

However, it is emphasized that medical detoxification is only the first stage or the precursor to effective drug addiction treatment. Medical detoxification must be implemented together with the collaborative and the concerted efforts of pertinent agencies that shall address the challenges of drug addiction in terms of the personal, health and societal aspects of drug rehabilitation.

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## II. GENERAL RULES

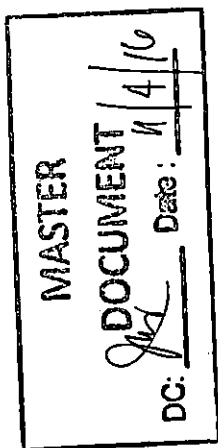
1. The provision of in-patient services by accredited levels 1, 2, and 3 government hospitals and Drug Abuse Treatment and Rehabilitation Centers licensed/certified by the Department of Health (DOH) to be accredited by PhilHealth for the first stage of drug addiction treatment shall be covered under the medical detoxification package.

If there is documented indication to treat a common co-morbidity associated with withdrawal symptoms arising from amphetamine use, the corresponding medical case rates may also be availed as an addition to the medical detoxification package (Annex "MD.1");

2. All eligible members and dependents of the National Health Insurance Program (NHIP) who need to undergo medical detoxification can avail of this package as a one-time benefit availment;
3. The No Balance Billing (NBB) Policy shall be applicable to indigent, sponsored, "kasambahay", lifetime and senior citizen categories who are admitted in ward accommodation in accredited government HCIs. In the event that they opt to choose a private accommodation, they shall waive the privilege of the no balance billing, thus, they may be charged by the provider the corresponding co-pay;
4. Co-pay of PhilHealth members admitted in government HCIs who are not eligible to NBB should not exceed the package rate for medical detoxification;
5. Applicable professional fees in ward accommodation under the no balance billing shall be 25% of the package rate;

Should there be an indication for the management of co-morbidity, the professional fees prescribed in the corresponding medical case rates shall be added to the total professional fees;

6. Rules on pooling of professional fees for government facilities shall apply;
7. Accredited HCIs providing the services for medical detoxification shall be subject to the rules of the Health Care Provider Assessment System (HCP PAS) and shall be disseminated in a separate issuance.
8. Specific policy and guidelines for accrediting DOH licensed/certified Drug Abuse Treatment and Rehabilitation Centers shall be disseminated in a separate issuance.



### III. CRITERIA, MINIMUM STANDARDS OF CARE AND PACKAGE RATE

1. Criteria for availment of the medical detoxification package are the following:
  - a. Eligible PhilHealth member or dependent;
  - b. Positive qualitative and/or quantitative urine test for methamphetamine;
  - c. Current history of methamphetamine (shabu) use including other amphetamine-type stimulants such as cocaine and methylene dioxymethamphetamine (ecstasy) or combination of these, with signs and symptoms of acute toxicity certified by the attending health care provider (Annex "MD.1").
  
2. The minimum standards of care included in the medical detoxification package lists the mandatory services to be provided by the accredited HCI are shown in Table 1:

Table 1. Mandatory and other services for medical detoxification

	Mandatory Services	Other services
Screening	Physical examination Mental status examination Neurological examination	-
Diagnostics	Urine qualitative or quantitative test for methamphetamine or amphetamine type stimulants Alanine aminotransferase(ALT) (baseline) Aspartate aminotransferase (AST) (baseline) Complete blood count Fasting blood sugar or random blood sugar Urine pH Serum Na, K, Cl Creatinine BUN CPK-MM or (CK total – CK MB) ECG Chest x-ray	-
Medicines	D <sub>5</sub> 0.9 NaCl (adult) OR D <sub>5</sub> 0.3 NaCl (pedia)	<b>As indicated only:</b> Activated charcoal Sodium sulfate Vitamin B complex Benzodiazepine Antipsychotic medicines D50-50 Acidification therapy with ascorbic acid

3. The package rate for medical detoxification shall be P10,000.00.

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**IV. CLAIMS FILING**

1. The accredited HCI shall file claims according to existing policies of PhilHealth;
2. All claims shall be filed by the accredited HCI in behalf of the clients. There shall be no direct filing by PhilHealth members;
3. The package code for medical detoxification is MD01;
4. A documented co-morbidity associated with withdrawal symptoms during drug treatment may be filed as an additional claim (Annex "MD.2") to the medical detoxification package;

Table 2. Claim application, code, amount and filing schedule

Claim application	Code	Amount (Php)	Filing schedule
Medical detoxification	MD01	10,000	Within 60 calendar days after discharge from the accredited HCI
Co-morbidity	ICD-10	Applicable case rate	

For all intents and purposes, there may or may not be an associated co-morbidity among clients undergoing medical detoxification. Thus, only one (1) major co-morbidity can be filed in addition to the medical detoxification package. The accredited HCI shall attach the checklist of co-morbidity form (Annex "MD.2") to the claims application for submission to PhilHealth. The attending accredited physician shall affix his/her signature to signify the truth and correctness of the said co-morbidity;

5. To file a claim for reimbursement, the accredited HCI shall submit a claim application and submit the following to PhilHealth:
  - a. PhilHealth Benefit Eligibility Form (PBEF) printout;
  - b. When the PBEF print-out indicates that the patient is not eligible to avail of PhilHealth benefits, the applicable documents may be attached (i.e. certificate of PhilHealth contributions, Claim Form 1, photocopy of official receipt of latest PhilHealth contribution, updated PhilHealth Member Registration Form or PMRF)
  - c. Properly accomplished Claim Form 2
    - i. Part I. Fill out item numbers 1, 2, 3;
    - ii. Part II. Fill out item numbers 1, 2, 3, 4, 5, 6, 7, 8b, 10;
    - iii. For Part II, number 8b, write the package code for medical detoxification
    - iv. If with co-morbidity, fill out Part II, Item 9a.
    - v. For Part II, item number 10, the attending physician must be PhilHealth accredited and must accomplish this part;

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- vi. Part IIIA. If without co-pay, check the first box. If with co-pay, check the second box. Completely fill out the required information indicated in the corresponding checked item. The statement of account shall be attached to the claim application;
- vii. Part IIIB. Accomplish this part;
- viii. Part IV. Accomplish this part.

d. Checklist of Mandatory and Other Services for Medical Detoxification (Annex "MD.3")

e. Detoxification Treatment Plan (Annex "MD.4")

f. Photocopy of completely accomplished Satisfaction Questionnaire (Annex "MD.5")

g. Checklist of Requirements for Reimbursement of Medical Detoxification Package (Annex "MD.6")

- 6. The List of signs and symptoms of acute toxicity (Annex "MD.1") and the results of diagnostic and laboratory tests are NOT required as attachments to the claim. However, these should be attached to the patient's chart and shall be checked during monitoring;
- 7. The Satisfaction Questionnaire (Annex "MD.5") shall be administered to all clients prior to discharge from the accredited HCI. These are validated during monitoring and shall be used as basis of the Corporation for benefits enhancement, policy research and quality improvement purposes;
- 8. Rules on late filing shall apply;
- 9. If the delay in filing of claims is due to natural calamities, or other fortuitous events, the accredited HCI shall be accorded an extension period of 60 calendar days as stipulated in Section 47 of the Implementing Rules and Regulation (IRR) of the National Health Insurance Act of 2013 (Republic Act 7875, as amended by RA 9241 and RA 10606).

**V. CLAIMS PAYMENT**

Payments shall be given as a single tranche to the accredited HCI.

**VI. POLICY REVIEW**

Pursuant to PhilHealth Circular No. 035-2015, a regular policy review shall be conducted in collaboration with all relevant stakeholders, experts and technical staff representatives from the Corporation.

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## VII. EFFECTIVITY

This circular shall take effect for all admissions 15 calendar days after its publication in the Official Gazette or in a newspaper of national circulation and shall be deposited thereafter at the Office of the National Administrative Register, University of the Philippines Law Center.

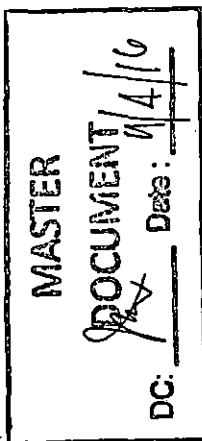
## VIII. ANNEXES

The following annexes may be downloaded from the PhilHealth website:  
[www.philhealth.gov.ph](http://www.philhealth.gov.ph)

1. List of signs and symptoms of acute toxicity (Annex "MD.1")
2. Co-morbidity Checklist (Annex "MD.2")
3. Checklist of Mandatory and Other Services for Medical Detoxification (Annex "MD.3")
4. Detoxification Treatment Plan (Annex "MD.4")
5. Satisfaction Questionnaire (Annex "MD.5")
6. Checklist of Requirements for Reimbursement of Medical Detoxification Package (Annex "MD.6")
7. Definition of terms (Annex "MD.7")
8. Pathway for Medical Detoxification (Annex "MD.8")

  
RAMON F. ARISTOZA, JR.  
Acting President & CEO

Date Signed: 11/3/16



Subject: Medical Detoxification Package

Benefits Development and Research Department

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## Signs and Symptoms of Acute Toxicity with Amphetamine Type Stimulant

**I. Symptoms**

<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Behavioral changes <input type="checkbox"/> Hyperpyrexia <input type="checkbox"/> Hypertension <input type="checkbox"/> Signs of circulatory collapse <input type="checkbox"/> Arrhythmias <input type="checkbox"/> Dilated pupils <input type="checkbox"/> Pallor or flushing <input type="checkbox"/> Tremors	<input type="checkbox"/> Headache <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Tremors <input type="checkbox"/> Delirium  <input type="checkbox"/> Mental status exam: <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoid ideations <input type="checkbox"/> Panic states
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**II. Hyperactivity Rating Scale for Amphetamine Overdose**

<b>1+</b>	<input type="checkbox"/> Restlessness <input type="checkbox"/> Irritability <input type="checkbox"/> Insomnia <input type="checkbox"/> Tremor <input type="checkbox"/> Hyperreflexia	<input type="checkbox"/> Diaphoresis <input type="checkbox"/> Mydriasis <input type="checkbox"/> Flushing
<b>2+</b>	<input type="checkbox"/> Hyperactivity <input type="checkbox"/> Confusion <input type="checkbox"/> Hypertension <input type="checkbox"/> Tachypnea	<input type="checkbox"/> Extrasystoles <input type="checkbox"/> Mild fever <input type="checkbox"/> Sweating
<b>3+</b>	<input type="checkbox"/> Delirium <input type="checkbox"/> Mania <input type="checkbox"/> Self-injury <input type="checkbox"/> Marked hypertension	<input type="checkbox"/> Tachypnea <input type="checkbox"/> Arrhythmias <input type="checkbox"/> Hyperpyrexia
<b>4+</b>	<input type="checkbox"/> Above symptoms plus: <input type="checkbox"/> Convulsions <input type="checkbox"/> Coma <input type="checkbox"/> Circulatory collapse <input type="checkbox"/> OR death	

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**Annex "MD.2 – Co-morbidity Checklist"**

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
CLIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF CLIENT <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>
MEMBER (if client is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>

**CO-MORBIDITY CHECKLIST**

Instruction: Place a check mark (✓) to one (1) major co-morbidity

CO-MORBIDITY	ICD.10	YES
<b>I. Substance use disorder</b>		
Poisoning by Psychostimulants with abuse potential	T43.6	
Mental and behavioural disorders due to use of cocaine	F14	
Mental and behavioural disorders due to use of other stimulants	F15	
Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances	F19	
<b>II. Psychosis</b>		
Psychotic disorders	F23	
Induced delusional disorder; Folie à deux; Induced paranoid disorder; Induced psychotic disorder	F24	
Schizoaffective disorders	F25	
Other nonorganic psychotic disorders; Chronic hallucinatory psychosis	F28	
Unspecified nonorganic psychosis; Psychosis	F29	
Hypomania; Mania with or without psychotic symptoms, Manic episode	F30	
Bipolar affective disorder	F31	
Mild to severe depressive episodes	F32	
Recurrent depressive disorder	F33	
Depressive personality disorders; anxiety depression	F34	
Mania without psychotic symptoms	F35	
<b>III. Ischemic heart disease with myocardial infarction</b>		
Acute transmural myocardial infarction	I21	
Subsequent myocardial infarction	I22	

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Instruction: Place a check mark (✓) to one (1) major co-morbidity

CO-MORBIDITY	ICD.10	Yes
IV. Dilated cardiomyopathy	I42	
V. Hypertensive crisis	I10.1	
Hypertension Stage II		
VI. Stroke		
Hemorrhagic Stroke – Subarachnoid hemorrhage	I60	
Hemorrhagic Stroke – Intracerebral hemorrhage	I61	
Hemorrhagic Stroke – Acute subdural hemorrhage	I62	
Cerebral infarction	I63	
VII. Seizures	G40.5	
Epileptic seizures related to alcohol; Epileptic seizures related to drugs		
VIII. Acute renal failure	N17.0	
Acute renal failure with tubular necrosis; Tubular necrosis NOS; Acute Tubular necrosis ; Renal Tubular necrosis		
IX. Gastrointestinal	K55.0	
Acute vascular disorders of intestine; Acute fulminant ischaemic colitis; Acute intestinal infarction; Acute small intestine ischaemia; Mesenteric artery embolism; Mesenteric vein embolism; Mesenteric artery infarction; Mesenteric vein infarction; Mesenteric artery thrombosis; Mesenteric vein thrombosis; Subacute ischaemic colitis		

Confome by:	Certified true and correct by:
(Printed name and signature) Client/Parent/Guardian	(Printed name and signature) Attending Physician
	PhilHealth Accreditation No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

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**PHILIPPINE HEALTH INSURANCE CORPORATION**

Citystate Centre, 709 Shaw Boulevard, Pasig City  
Call Center (02) 441-7442 Trunkline (02) 441-7444  
[www.philhealth.gov.ph](http://www.philhealth.gov.ph)



**Annex "MD.3 – Checklist of Mandatory Services"**

HEALTH CARE INSTITUTION (HCI)	
ADDRESS OF HCI	
PATIENT (Last name, First name, Middle name, Suffix)	
PHILHEALTH ID NUMBER OF PATIENT	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)	
PHILHEALTH ID NUMBER OF MEMBER	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>

**CHECKLIST OF MANDATORY AND OTHER SERVICES**  
**Medical Detoxification Package**

Place a (✓) in the status column if DONE or NA if not applicable.

MANDATORY AND OTHER SERVICES	Status
1. Screening	
a. Physical examination	
b. Mental status examination	
c. Neurological examination	
2. Diagnostics	
a. Urine qualitative or quantitative test for methamphetamine or amphetamine type stimulants	
b. Alanine aminotransferase(ALT) (baseline)	
c. Aspartate aminotransferase (AST) (baseline)	
d. Complete blood count	
e. Fasting blood sugar or random blood sugar	
f. Urine pH	
g. Serum Na, K, Cl	
h. Creatinine	
i. BUN	
j. CPK-MM or (CK total – CK MB)	
k. ECG	
l. Chest X-ray	


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Place a (✓) in the status column if DONE or NA if not applicable.

MANDATORY AND OTHER SERVICES	Status
3. Medicines	
a. D <sub>5</sub> 0.9 NaCl (adult) or D <sub>5</sub> 0.3 NaCl (pedia)	
b. Activated charcoal, as indicated	
c. Sodium sulfate, as indicated	
d. Vitamin B complex, as indicated	
e. Benzodiazepine, as indicated	
f. Antipsychotic medicines, as indicated	
g. D50-50, as indicated	
h. Acidification therapy with ascorbic acid, as indicated	

Certified true and correct by:		Certified true and correct by:	
(Printed name and signature) Attending Physician		(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief	
PhilHealth Accreditation No.	-	PhilHealth Accreditation No.	-
Date signed (mm/dd/yyyy)		Date signed (mm/dd/yyyy)	

Conforme by:
(Printed name and signature) Patient/Parent/Guardian
Date signed (mm/dd/yyyy)

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**Annex "MD.4 – Detoxification Treatment Plan"**

**DETOXIFICATION TREATMENT PLAN**  
**Medical Detoxification**

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
CLIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF CLIENT <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>
MEMBER (if client is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>

DETOXIFICATION TREATMENT PLAN	

Conforme by:	Certified true and correct by:
(Printed name and signature) Client/Parent/Guardian	(Printed name and signature) Attending Physician
	PhilHealth Accreditation No. <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>

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**Annex "MD.5 – Satisfaction Questionnaire"**

**Satisfaction Questionnaire**

**Instruction:** We would like to know how you feel about the services that pertain to the Medical Detoxification Package in order that we can improve and meet your needs. This survey will only take a few minutes. Please read the items carefully. If you need to clarify items or ask questions, you may approach your friendly health care provider or you may contact PhilHealth call center at 441-7442. Your responses will be kept confidential and anonymous.

For items 1 to 2, please tick on the appropriate box.

1. Respondent's age is:
  - 19 years old & below
  - between 20 to 35
  - between 36 to 45
  - between 46 to 55
  - between 56 to 65
  - above 65 years old

2. Sex of respondent
  - male
  - female

For items 3 to 7, please select the one best response by ticking the appropriate box.

3. How would you rate the services received from the health care institution (HCI) in terms of availability of medicines or supplies needed for the treatment of your condition?
  - adequate
  - inadequate
  - don't know

How would you rate the patient's or family's involvement in the care of the client?

- excellent
- satisfactory
- unsatisfactory
- don't know

5. In general, how would you rate the health care professionals that provided the services for the medical detoxification package in terms of doctor-client relationship?
  - excellent
  - satisfactory
  - unsatisfactory
  - don't know

6. In your opinion, by how much has your HCI expenses been lessened by availing of the PhilHealth benefit package?
  - less than half
  - by half
  - more than half
  - don't know

7. Overall patient satisfaction (PS mark) is:
  - excellent
  - satisfactory
  - unsatisfactory
  - don't know

8. If you have other comments, please share them below:

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Thank you. Your feedback is important to us!

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**Annex "MD.6 – Checklist of Requirements for Reimbursement"**

HEALTH CARE INSTITUTION (HCI)	
ADDRESS OF HCI	
PATIENT (Last name, First name, Middle name, Suffix)	
PHILHEALTH ID NUMBER OF PATIENT	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)	
PHILHEALTH ID NUMBER OF MEMBER	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>

**CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT**  
**Medical Detoxification Package**

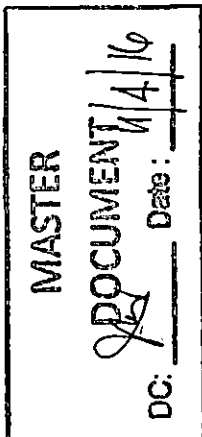
Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex MD.6)	
2. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
3. Co-Morbidity Checklist (Annex MD.2)	
4. Checklist of Mandatory and Other Services (Annex MD.3)	
5. Detoxification Treatment Plan (Annex MD.4)	
6. Photocopy of completed Satisfaction Questionnaire (Annex MD.5)	

Conforme by:  (Printed name and signature) Client/Parent/Guardian	Certified true and correct by:  (Printed name and signature) Attending Physician PhilHealth Accreditation No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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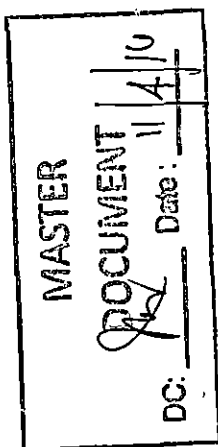
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## Definition of Terms

Addiction	The repeated use of a psychoactive substance or substances, to the extent that the user (referred to as an addict) is periodically or chronically intoxicated, shows a compulsion to take the preferred substance (or substances), has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain psychoactive substances by almost any means.
Confirmatory test	An analytical test using a device, tool or equipment with a different chemical or physical principle that is more specific which will validate and confirm the result of the screening test.
Dangerous drugs	Include those listed in the Schedules annexed to the 1961 Single Convention on Narcotic Drugs, as amended by the 1972 Protocol, and in the Schedules annexed to the 1971 Single Convention on Psychotropic Substances as enumerated in the attached annex which is an integral part of this Act.
Drug abuse	In the context of international drug control, drug abuse constitutes the use of any substance under international control for purposes other than medical and scientific, including use without prescription, in excessive dose levels, or over an unjustified period of time.
Intoxication	A condition that follows the administration of a sufficient amount of a psychoactive substance and which results in disturbances in the level of consciousness, cognition, perception, judgement, affect, behaviour, or other psychophysiological functions and responses.
Medical detoxification	The initial and acute stage of drug treatment. The process by which a person who is dependent on a psychoactive substance ceases use, in such a way that minimizes the symptoms of withdrawal and risk of harm. While the term "detoxification" literally implies a removal of toxic effects from an episode of drug use, in fact it has come to be used to refer to the management of rebound symptoms of neuroadaptation, that is, withdrawal and any associated physical and mental health problems.

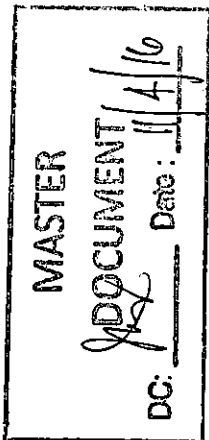


Methamphetamine hydrochloride	commonly known as "Shabu", "Ice", "Meth", or by its any other name. Refers to the drug having such chemical composition, including any of its isomers or derivatives in any form.
Methylenedioxyamphet-amine (MDMA)	commonly known as "Ecstasy", or by its any other name. Refers to the drug having such chemical composition, including any of its isomers or derivatives in any form.
Rehabilitation	In the field of substance use, the process by which an individual with a drug-related problem achieves an optimal state of health, psychological functioning and social well-being.
Screening	A rapid procedure designed to detect individuals who have a substance abuse problem.
Substance abuse	A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. There may be repeated failure to fulfil major role obligations, repeated use in situations in which it is physically hazardous, multiple legal problems, and recurrent social and interpersonal problems.
Substance dependence	A cluster of cognitive, behavioural and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that usually results in tolerance, withdrawal and compulsive drug-taking behaviour.
Substance use disorder	Any mental or behavioural disorder resulting from the use of one or more psychoactive substances, whether or not medically prescribed. The substances specified are alcohol, opioids, cannabinoids, sedatives or hypnotics, cocaine, other stimulants (including caffeine), hallucinogens, tobacco, and volatile solvents. The clinical states that may occur include acute intoxication, harmful use, dependence syndrome, withdrawal state, withdrawal state with delirium, psychotic disorder, late-onset psychotic disorder and amnesic syndrome.





Treatment	The process that begins when psychoactive substance abusers come into contact with a health provider or any other community service and may continue through a succession of specific interventions until the highest attainable level of health and well being is reached". More specifically, treatment may be defined "... as a comprehensive approach to the identification, assistance, ... (and) ... health care ... with regard to persons presenting problems caused by the use of any psychoactive substance".
Withdrawal	Refers to either the individual symptoms of, or the overall state (or syndrome), which may result when a person ceases use of a particular psychoactive drug upon which they have become dependent or after a period of repeated exposure.
Withdrawal syndrome	A group of symptoms of variable severity which occur on cessation or reduction of drug use after a prolonged period of use and/or in high doses. The syndrome may be accompanied by signs of both psychological and physiological disturbance.



**CLINICAL PATHWAY  
MEDICAL DETOXIFICATION**

**INCLUSION CRITERIA:**

1. Positive qualitative and/or quantitative urine test for methamphetamine;
2. Current history of methamphetamine (shabu) use including other amphetamine- type stimulants such as cocaine and methylene dioxymethamphetamine (ecstasy) or combination of these, with signs and symptoms of acute toxicity certified by the attending health care provider.

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ GENDER: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ CIVIL STATUS: \_\_\_\_\_  
 CONTACT NUMBER: \_\_\_\_\_ HOSPITAL NUMBER: \_\_\_\_\_  
 EDUCATIONAL ATTAINMENT: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

**DAY 1**

I.HISTORY & P.E.		PHYSICIAN'S NOTES:	VARIANCE
<b>A. Exposure History</b>			
Number of Agents: _____  Substance: _____  Route of Exposure: _____  Type of Exposure: _____  Time since last Exposure: _____  Location of Exposure: _____	<input type="radio"/> Single <input type="radio"/> Multiple  <input type="radio"/> Methamphetamine <input type="radio"/> MDMA <input type="radio"/> Other Stimulants  <input type="radio"/> Ingestion <input type="radio"/> Injection: _____ <input type="radio"/> Inhalation <input type="radio"/> Mixed: _____  <input type="radio"/> Acute <input type="radio"/> Chronic If chronic, Duration of Exposure: _____ Years                      _____ Months _____ Weeks                      _____ Days Frequency of Exposure: _____ Amount : _____  _____ Years _____ Months _____ Weeks _____ Days  <input type="radio"/> Home <input type="radio"/> Neighbor/Friend's place <input type="radio"/> Workplace <input type="radio"/> Others _____		

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NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ GENDER: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ CIVIL STATUS: \_\_\_\_\_  
 CONTACT NUMBER: \_\_\_\_\_ HOSPITAL NUMBER: \_\_\_\_\_  
 EDUCATIONAL ATTAINMENT: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

DAY 1

III. DIAGNOSTICS				VARIANCE
YES	NO			
<input type="radio"/>	<input type="radio"/>	a. Urine qualitative or quantitative test for Map or amphetamine type stimulants	<input type="radio"/> Positive <input type="radio"/> Negative	
<input type="radio"/>	<input type="radio"/>	a. Urine Ph	<input type="radio"/> 5.0 <input type="radio"/> 6.0 <input type="radio"/> 6.5 <input type="radio"/> 7.0 <input type="radio"/> 7.5 <input type="radio"/> 8.0 <input type="radio"/> 9.0	
<input type="radio"/>	<input type="radio"/>	b. Alanine aminotransferase (ALT) (baseline)	_____	
<input type="radio"/>	<input type="radio"/>	c. Aspartate aminotransferase (AST) (Baseline)	_____	
<input type="radio"/>	<input type="radio"/>	d. Complete blood count	Hgb: _____ Hct: _____ WBC: _____ Plt. Ct _____ Differential Count: _____	
<input type="radio"/>	<input type="radio"/>	e. FBS or RBS	_____	
<input type="radio"/>	<input type="radio"/>	f. Electrolytes	Na: _____ K: _____ Cl: _____	
<input type="radio"/>	<input type="radio"/>	g. Creatinine	_____	
<input type="radio"/>	<input type="radio"/>	h. BUN	_____	
<input type="radio"/>	<input type="radio"/>	i. CPK-MM or CK total – CK MB)	_____	
<input type="radio"/>	<input type="radio"/>	j. ECG	_____	
<input type="radio"/>	<input type="radio"/>	k. Chest X-ray	_____	

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NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ GENDER: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ CIVIL STATUS: \_\_\_\_\_  
 CONTACT NUMBER: \_\_\_\_\_ HOSPITAL NUMBER: \_\_\_\_\_  
 EDUCATIONAL ATTAINMENT: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

DAY 1

IV. THERAPEUTICS			VARIANCE
YES	NO	# of Doses (If Yes)	
<input type="radio"/>	<input type="radio"/>	a. D5 0.9 NaCl or D5 0.3 NaCl	
<input type="radio"/>	<input type="radio"/>	b. Activated Charcoal	
<input type="radio"/>	<input type="radio"/>	c. Sodium Sulfate	
<input type="radio"/>	<input type="radio"/>	d. Ascorbic Acid	
<input type="radio"/>	<input type="radio"/>	e. Diazepam	
<input type="radio"/>	<input type="radio"/>	Others _____	

V. SUPPORTIVE			
YES	NO		
<input type="radio"/>	<input type="radio"/>	Refer to Psychiatry service	
<input type="radio"/>	<input type="radio"/>	Refer to other specialty service (as needed) _____	

<p><b>ACTIVATED BY:</b></p>  <p style="text-align: center;">Attending Physician (Name and Signature)</p> <p>PhilHealth Accreditation No. _____</p>	<p><b>ACKNOWLEDGED BY:</b></p>  <p style="text-align: center;">Nurse on Duty (Name and Signature)</p> <p>PRC License No. _____</p>
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VARIANCE CODES		
A. CLIENT	B. CAREGIVER	C. SYSTEM
1. Client too sick	1. Physician provider error	1. Bed availability
2. Comorbid interference	2. Lack of or inadequate documentation	2. Schedule conflict
3. Client cognitive status	3. Time orders were written	3. Consultant unavailable
4. Client/family decision	4. Time orders were written	4. Therapist unavailable
5. Psychological/emotional status	5. Orders outside clinical pathway parameters	5. Results/data unavailable
6. Inability to learn skill needed	6. Physician response time	6. Supply/equipment unavailable
7. Inadequate family/social support	7. Other provider response time	7. Department closed
8. Not indicated at this time		8. Placement unavailable
9. Unable to return to preadmission environment		9. Home health care unavailable
10. Client condition warrants early discontinuance		10. Pending payer approval
11. Client noncompliance		11. Lack of equipment
12. Caregiver difficulties		12. Not applicable (explain)
		13. Other (explain)

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**CLINICAL PATHWAY  
MEDICAL DETOXIFICATION**

**INCLUSION CRITERIA:**

1. Positive qualitative and/or quantitative urine test for methamphetamine;
2. Current history of methamphetamine (shabu) use including other amphetamine- type stimulants such as cocaine and methylene dioxymethamphetamine (ecstasy) or combination of these, with signs and symptoms of acute toxicity certified by the attending health care provider.

**NAME:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **GENDER:** \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_ **CIVIL STATUS:** \_\_\_\_\_  
**CONTACT NUMBER:** \_\_\_\_\_ **HOSPITAL NUMBER:** \_\_\_\_\_  
**EDUCATIONAL ATTAINMENT:** \_\_\_\_\_ **OCCUPATION:** \_\_\_\_\_

**DAY 2**

I. Signs and Symptoms			VARIANCE
<b>Secondary to Substance Use?</b>			
Yes	No		
○	○	1. Nausea	
○	○	2. Vomiting	
○	○	3. Diarrhea	
○	○	4. Behavioral Changes	
○	○	5. Hyperpyrexia	
○	○	6. Hypertension	
○	○	7. Signs of circulatory collapse	
○	○	8. Arrhythmias	
○	○	9. Dilated pupils	
○	○	10. Pallor or flushing	
○	○	11. Tremors	
○	○	12. Headache	
○	○	13. Excessive sweating	
○	○	14. Delirium	
○	○	15. Palpitations	
○	○	16. Mental Status Exam	
○	○	17. Hallucinations	
○	○	18. Paranoid ideations	
○	○	19. Panic states	

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 DC: \_\_\_\_\_ Date: 11/4/16



NAME: _____	AGE: _____ GENDER: _____
ADDRESS: _____	CIVIL STATUS: _____
CONTACT NUMBER: _____	HOSPITAL NUMBER: _____
EDUCATIONAL ATTAINMENT: _____	OCCUPATION: _____

**DAY 2**

III. THERAPEUTICS			# of Doses (If Yes)	VARIANCE
YES	NO			
<input type="radio"/>	<input type="radio"/>	a. D5 0.9 NaCl or D5 0.3 NaCl	_____	
<input type="radio"/>	<input type="radio"/>	b. Activated Charcoal	_____	
<input type="radio"/>	<input type="radio"/>	c. Sodium Sulfate	_____	
<input type="radio"/>	<input type="radio"/>	d. Ascorbic Acid	_____	
<input type="radio"/>	<input type="radio"/>	e. Diazepam _____	_____	
<input type="radio"/>	<input type="radio"/>	f. Others _____	_____	

<p><b>ACTIVATED BY:</b></p>  <p style="text-align: center;">Attending Physician (Name and Signature) PhilHealth Accreditation No. _____</p>	<p><b>ACKNOWLEDGED BY:</b></p>  <p style="text-align: center;">Nurse on Duty (Name and Signature) PRC License No. _____</p>
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VARIANCE CODES		
A. CLIENT	B. CAREGIVER	C. SYSTEM
<ol style="list-style-type: none"> <li>1. Client too sick</li> <li>2. Comorbid interference</li> <li>3. Client cognitive status</li> <li>4. Client/family decision</li> <li>5. Psychological/emotional status</li> <li>6. Inability to learn skill needed</li> <li>7. Inadequate family/social support</li> <li>8. Not indicated at this time</li> <li>9. Unable to return to preadmission environment</li> <li>10. Client condition warrants early discontinuance</li> <li>11. Client noncompliance</li> <li>12. Caregiver difficulties</li> </ol>	<ol style="list-style-type: none"> <li>1. Physician provider error</li> <li>2. Lack of or inadequate documentation</li> <li>3. Time orders were written</li> <li>4. Time orders were written</li> <li>5. Orders outside clinical pathway parameters</li> <li>6. Physician response time</li> <li>7. Other provider response time</li> </ol>	<ol style="list-style-type: none"> <li>1. Bed availability</li> <li>2. Schedule conflict</li> <li>3. Consultant unavailable</li> <li>4. Therapist unavailable</li> <li>5. Results/data unavailable</li> <li>6. Supply/equipment unavailable</li> <li>7. Department closed</li> <li>8. Placement unavailable</li> <li>9. Home health care unavailable</li> <li>10. Pending payer approval</li> <li>11. Lack of equipment</li> <li>12. Not applicable (explain)</li> <li>13. Other (explain)</li> </ol>

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Date: 4/16

DC: \_\_\_\_\_



**CLINICAL PATHWAY  
MEDICAL DETOXIFICATION**

**INCLUSION CRITERIA:**

- 3. Positive qualitative and/or quantitative urine test for methamphetamine;
- 4. Current history of methamphetamine (shabu) use including other amphetamine- type stimulants such as cocaine and methylene dioxymethamphetamine (ecstasy) or combination of these, with signs and symptoms of acute toxicity certified by the attending health care provider.

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ GENDER: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ CIVIL STATUS: \_\_\_\_\_  
 CONTACT NUMBER: \_\_\_\_\_ HOSPITAL NUMBER: \_\_\_\_\_  
 EDUCATIONAL ATTAINMENT: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

**DAY 3**

I. Signs and Symptoms			VARIANCE
<b>Secondary to Substance Use?</b>			
<b>Yes</b>	<b>No</b>		
○	○	1. Nausea	
○	○	2. Vomiting	
○	○	3. Diarrhea	
○	○	4. Behavioral Changes	
○	○	5. Hyperpyrexia	
○	○	6. Hypertension	
○	○	7. Signs of circulatory collapse	
○	○	8. Arrhythmias	
○	○	9. Dilated pupils	
○	○	10. Pallor or flushing	
○	○	11. Tremors	
○	○	12. Headache	
○	○	13. Excessive sweating	
○	○	14. Delirium	
○	○	15. Palpitations	
○	○	16. Mental Status Exam	
○	○	17. Hallucinations	
○	○	18. Paranoid ideations	
○	○	19. Panic states	

**MASTER DOCUMENT**  
 DC: \_\_\_\_\_ Date: 11/4/16

NAME: _____	AGE: _____ GENDER: _____
ADDRESS: _____	CIVIL STATUS: _____
CONTACT NUMBER: _____	HOSPITAL NUMBER: _____
EDUCATIONAL ATTAINMENT: _____	OCCUPATION: _____

**DAY 3**

II. HYPERACTIVITY RATING SCALE FOR AMPHETAMINE OVERDOSE		VARIANCE
1+	<input type="radio"/> Restlessness <input type="radio"/> Diaphoresis <input type="radio"/> Irritability <input type="radio"/> Mydriasis <input type="radio"/> Insomnia <input type="radio"/> Flushing <input type="radio"/> Tremor <input type="radio"/> Hyperreflexia	
2+	<input type="radio"/> Hyperactivity <input type="radio"/> Extrasystoles <input type="radio"/> Confusion <input type="radio"/> Mild Fever <input type="radio"/> Hypertension <input type="radio"/> Sweating <input type="radio"/> Tachypnea	
3+	<input type="radio"/> Delirium <input type="radio"/> Tachypnea <input type="radio"/> Mania <input type="radio"/> Arrhythmias <input type="radio"/> Self-injury <input type="radio"/> Hyperpyrexia <input type="radio"/> Marked hypertension	
4+	Above symptoms plus: <input type="radio"/> Convulsions <input type="radio"/> coma <input type="radio"/> Circulatory Collapse <input type="radio"/> Death	
III. DIAGNOSTICS		
YES	NO	
<input type="radio"/>	<input type="radio"/>	a. Urine qualitative or quantitative test for Map or amphetamine type stimulants <input type="radio"/> Positive <input type="radio"/> Negative
<input type="radio"/>	<input type="radio"/>	b. Urine Ph <input type="radio"/> 5.0 <input type="radio"/> 6.0 <input type="radio"/> 6.5 <input type="radio"/> 7.0 <input type="radio"/> 7.5 <input type="radio"/> 8.0 <input type="radio"/> 9.0
<input type="radio"/>	<input type="radio"/>	c. Electrolytes Na: _____ K: _____ Cl: _____
<input type="radio"/>	<input type="radio"/>	d. Creatinine _____
<input type="radio"/>	<input type="radio"/>	e. BUN _____
<input type="radio"/>	<input type="radio"/>	f. CPK-MM or CK total – CK MB) _____
<input type="radio"/>	<input type="radio"/>	g. Others _____

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 DC: \_\_\_\_\_ Date: \_\_\_\_\_

NAME: _____		AGE: _____	GENDER: _____
ADDRESS: _____		CIVIL STATUS: _____	
CONTACT NUMBER: _____		HOSPITAL NUMBER: _____	
EDUCATIONAL ATTAINMENT: _____		OCCUPATION: _____	
<b>DAY 3</b>			
III. THERAPEUTICS		VARIANCE	
YES	NO	# of Doses (If Yes)	
○	○		
○	○		
○	○		
○	○		
○	○		
○	○		
		a. D5 0.9 NaCl or D5 0.3 NaCl	_____
		b. Activated Charcoal	_____
		c. Sodium Sulfate	_____
		d. d. Ascorbic Acid	_____
		e. Diazepam	_____
		f. Others _____	
<b>ACTIVATED BY:</b>		<b>ACKNOWLEDGED BY:</b>	
_____ Attending Physician (Name and Signature) PhilHealth Accreditation No. _____		_____ Nurse on Duty (Name and Signature) PRC License No. _____	

VARIANCE CODES		
A. CLIENT	B. CAREGIVER	C. SYSTEM
1. Client too sick	1. Physician provider error	1. Bed availability
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11. Client noncompliance		11. Lack of equipment
12. Caregiver difficulties		12. Not applicable (explain)
		13. Other (explain)

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 Date: 11/4/16