Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 Trunkline (02) 441-7444
www.philhealth.gov.ph

PHILHEALTH CIRCULAR
No. 2019- 0005

TO : ALL PHILHEALTH MEMBERS, ACCREDITED AND CONTRACTED HEALTH CARE PROVIDERS, PHILHEALTH REGIONAL OFFICES AND ALL OTHERS CONCERNED

SUBJECT : **Outpatient Benefit Package for the Secondary Prevention of Rheumatic Fever/Rheumatic Heart Disease**

I. BACKGROUND

Rheumatic fever (RF)/rheumatic heart disease (RHD) continue to be the leading cause of acquired heart disease in children and adults in the Philippines, especially affecting those living in overcrowded and marginalized sectors of society. RF/RHD is included in the top 20% of high burden conditions in the Philippines (IHME 2017). The prevalence rate is estimated at 1/1,000 school children aged 5 to 10, and accounts for 40% of all cardiac admissions. (DOH, Philippines, 2010) As of 2006, RHD ranks as the 24th top cause of death and the 4th leading cause of adolescent mortality in the Philippines (Carrascoso-Cuartero, 2015). The causative agent leading to RF/RHD is group A beta-hemolytic streptococci (GAS), which causes a pharyngeal infection followed by a latent period of approximately two to three weeks and an autoimmune process marked by inflammatory reaction in the heart, joints, skin, subcutaneous tissue and central nervous system. The recurrence of streptococcal infection cascades the progressive destructive effect on the heart valves that leads to the chronic sequelae of the disease or the chronic valvulopathy of RHD (Stage A and B). Progressive valve changes leads to valve regurgitation and/or stenosis, chamber dilatation (Stage C) and to hemodynamic disturbances causing heart failure (Stage D), arrhythmias, and other complications such as stroke and infective endocarditis.

II. RATIONALE

The 71st World Health Assembly 2018 recognizes that RF/RHD is a preventable disease and with evidence for cost-effective interventions that are crucial for the eradication of the disease.

By providing coverage for the secondary prophylaxis of RF/RHD under the National Health Insurance Program, the natural history of the disease is intended to reverse as well as the percentage of patients requiring valve surgery among adults in the next ten years. Through the PhilHealth outpatient benefit package for RF/RHD, as approved by the PhilHealth Board (PhilHealth Board Resolution No. 2368 s. 2018), catastrophic health expenditures for the management of RF/RHD complications as well as the need for valve surgery can be minimized significantly.

III. OBJECTIVE

This circular aims to define the policies and procedures for the implementation of outpatient benefit package for the secondary prevention of RF/RHD.

IV. SCOPE

This Circular shall apply to all accredited health care institutions (HCI) that are contracted to provide the defined mandatory services for the secondary prevention of RF/RHD in the outpatient setting.

V. DEFINITION OF TERMS

A. Antibiotic prophylaxis – refers to the prevention of infection complications using antimicrobial therapy (most commonly antibiotics)

B. Lost to follow up – means the patient has not come back for injection for four consecutive visits from the next scheduled injection

C. Mandatory services – minimum standards of care that contracted health care institutions should provide to beneficiaries of the National Health Insurance Program

D. Modified Jones Criteria – a guide used to diagnose RF/RHD based on signs and symptoms, classified as major and minor manifestations, for patients with RF/RHD

E. Multidisciplinary-interdisciplinary team (MDT) approach to patient care– each discipline respecting the role and expertise of the other, in the delivery of complete managed care and course of treatment which comprises all mandatory and other services required to produce the desired health outcome

F. Other services – additional services other than the minimum standards of care that may be necessary to provide quality care, which are based on clinical guidelines and current standards of care that are acceptable by the Corporation

G. Rheumatic fever (RF) – an inflammatory, systemic disease, caused by group A beta – hemolytic streptococcus.

H. Rheumatic heart disease (RHD) – a disease condition of the heart due to the complication of rheumatic fever in which the heart valves are damaged

I. Secondary prophylaxis for RF/RHD - refers to the continuous antimicrobial prophylaxis to provide the most effective protection from recurrences of RF

VI. SPECIFIC GUIDELINES

A. CONTRACTING HEALTH CARE INSTITUTIONS AS PROVIDERS FOR THE OUTPATIENT BENEFIT PACKAGE FOR RHEUMATIC FEVER/RHEUMATIC HEART DISEASE

With the mandate of the National Health Insurance Program to pay for quality health care services, the Corporation has the prerogative to negotiate and enter into contracts with PhilHealth-accredited HCIs for the provision of the mandatory services of the outpatient benefit package for RF/RHD following the guidelines for contracting.

Coordination and collaboration with the contracted HCIs for this benefit package shall be required for quality improvement and operational purposes, such as, but not limited to, pertinent training, regular patient audits, patient referrals, patient tracking, and pooled procurement of drugs and supplies, etc.

The contracted HCI shall designate at least one RF/RHD coordinator who shall guide and navigate patients to ensure adherence to agreed treatment plan, track and record patient visits and follow-ups, encode patient data, track the validity of approved pre-authorization requests per patient and coordinate with the concerned PhilHealth Regional Office to ensure completeness and accuracy of all attachments needed for pre-authorization and claims application to facilitate reimbursement.

B. MINIMUM STANDARDS OF CARE

The outpatient benefit package for RF/RHD shall include the following healthcare services (Table 1).

Table 1. Mandatory and other services for the outpatient benefit package for RF/RHD

Mandatory Services (Minimum Standards of Care)	Other services
A. Secondary prophylaxis using: Injections with penicillin G benzathine (benzathine benzylpenicillin), 1.2 M units, vial (modified release or MR) (intramuscular or IM) OR, if with indications (Annex "J") oral secondary prophylaxis with phenoxymethyl penicillin (penicillin V) (as potassium salt) or oral erythromycin B. Diagnostic test • 2D echo cardiogram (at least once a year during the second tranche)	A. Medicines • aspirin • prednisone • antacids B. Laboratory tests • Erythrocyte sedimentation rate (ESR) • C-reactive protein (CRP) • Antistreptolysin O (ASO) Titer • Complete blood count (CBC) with platelets C. Diagnostic tests • Electrocardiogram (EKG/ECG) • Chest x-ray

C. AVAILMENT OF THE OUTPATIENT BENEFIT PACKAGE FOR RHEUMATIC FEVER/RHEUMATIC HEART DISEASE

1. Criteria for availment of the package

a. Fulfills membership eligibility for availment of PhilHealth benefits

b. Fulfills **any** of the following clinical criteria or stage of cardiac involvement for the availment of the outpatient benefit package for RF/RHD:

i. Stage A
Valve involvement based on Modified Jones Criteria

ii. Stage B, with **all** of the following:
ii.1 Progressive valve disease (mild to moderate severity and asymptomatic)
ii.2 Normal left ventricular (LV) size and function

iii. Stage C, with **all** of the following:
- iii.1 Moderate to severe valve involvement
- iii.2 Left ventricle enlargement
- iii.3 No heart failure
- iii.4 Functional class I-II

iv. Stage D, with **all** of the following:
- iv.1 Severe valve involvement or multiple
- iv.2 Left ventricle enlargement
- iv.3 With heart failure
- iv.4 Functional class III-IV

2. Pre-authorization

a. Once the member fulfills the eligibility and clinical criteria for availment of the outpatient benefit package for RF/RHD, the contracted HCI shall proceed with the process of seeking approval for pre-authorization

b. While the contracted HCI is seeking approval of their pre-authorization request from PhilHealth, the designated staff in the contracted HCI should already administer the first dose of IM injection of penicillin G benzathine to the patient who requires the IM injection route and this should be documented accordingly in the patient record.

Patients who are beneficiaries of the sponsored program or are indigents should not be charged out-of-pocket for receiving the service;

c. The pre-authorization process involves the following steps:

i. The contracted HCI must completely accomplish all forms required for pre-authorization prior to submission of the Pre-authorization Checklist and Request (Annex "A");

ii. While the process of pre-authorization is not yet automated, a designated liaison of the contracted HCI shall submit the pre-authorization request with the required attachments to the office of the Head of the PhilHealth Benefits Administration Section (BAS) in the region or to the Local Health Insurance Office (LHIO). Attachments to the pre-authorization request are the properly accomplished member empowerment form (ME Form, Annex "B") and the PhilHealth Benefit Eligibility Form (PBEF).

iii. The ME Form shall be discussed by the attending health care professional/s and accomplished together with the parent/guardian or patient to be enrolled in the Outpatient Benefit Package for RF/RHD. The ME Form aims to support parent/guardian or

patients to become active participants in health care decision making by being educated and informed of the conditions and all management options. Further, the ME Form aims to encourage the attending health care professionals in the contracted HCIs to dedicate adequate time to discuss treatment options with patients. The primary objectives of the member empowerment are to achieve better health outcomes and patient satisfaction.

iv. The approved/disapproved Pre-authorization Checklist and Request shall be returned to the contracted HCI within five (5) working days;

v. It is the contracted HCI's responsibility to remind their patients, as applicable, to update their premium contributions to ensure that these patients are eligible during the entire period of availment of the RF/RHD outpatient benefit package.

3. Validity of the approved pre – authorization request

The approved pre – authorization request shall be valid within 12 months from the date of approval. The 2D echo must be done at least within 12 months for stages A and B and within 6 months for stages C and D from date of application receipt of the pre-authorization request.

All contracted HCIs are responsible for tracking the validity of their approved pre-authorization requests. The contracted HCI shall inform PhilHealth when the validity of the approved pre-authorization request has lapsed. A new Pre-Authorization Checklist and Request may be submitted to PhilHealth if the mandatory services were not provided at the end of the validity period of the prior request.

a. Five days shall be deducted from the 45-day annual benefit limit upon approval of the application for pre-authorization. The member or the dependent should have at least one day remaining from the 45-day annual benefit limit prior to submission of the Pre-authorization Checklist and Request.

b. An approved Pre-authorization Checklist and Request guarantees payment of the first tranche of the outpatient benefit package provided that mandatory services for the specified treatment phase are given to the patient and all other PhilHealth requirements are complied with.

4. Package Rate, Rules on Co-pay and Electronic Medical Records

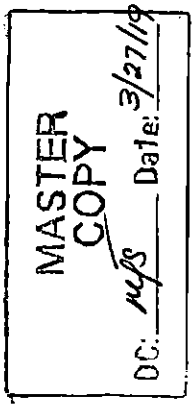
a. The package code for RF/RHD is RFRHD.

b. The corresponding reimbursement rate for the Benefit Package for RF/RHD is Php12,000.00 per patient in a given fiscal year. Payment shall be in two tranches that shall be reimbursed directly to the contracted HCI.

Each tranche payment will be paid in the amount of Php 6,000.00.

Table 2. Filing schedule

Mode of reimbursement	Filing Schedule for Secondary Prophylaxis		
	21-day secondary prophylaxis with penicillin G benzathine (benzathine benzylpenicillin)	**28-day secondary prophylaxis with penicillin G benzathine (benzathine benzylpenicillin)**	**Oral secondary prophylaxis with phenoxymethyl penicillin (penicillin V) (as potassium salt) or oral erythromycin**
Tranche 1	Within 60 days after the 10th IM injection	Within 60 days after the 7th IM injection	Within 60 days after the last intake in the 6th month of oral secondary prophylaxis
Tranche 2	Within 60 days after the 17th IM injection	Within 60 days after the 13th IM injection	Within 60 days after the last intake in the 12th month of oral secondary prophylaxis



c. The contracted HCI shall establish or develop its internal guidelines and process regarding allocation of hospital and professional fees after PhilHealth reimbursements.

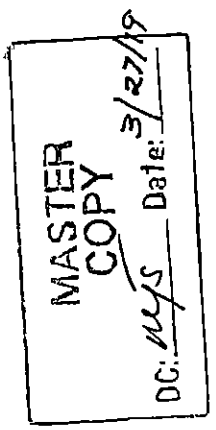
   Rules on pooling of professional fees in government hospitals shall be followed (DOH AO 2016-0033).

d. Indigent and Sponsored Program members should not be charged out of pocket for services received when availing of the RF/RHD outpatient benefit package.

e. A co-pay ceiling shall be reflected in the individual contracts of HCIs for eligible non–sponsored members and their qualified dependents to cover for additional services beyond the benefit package and patient requests for private consults. However, it is highly encouraged that no additional fees be charged to PhilHealth members and their dependents.

f. All mandatory services shall be provided according to the minimum standards set in the package. Based on evidence updates and current standards of local practice, the mandatory services shall also undergo updates during policy review in collaboration with experts and stakeholders.

g. Contracted HCIs are required to have an electronic medical record (EMR) of all their RF/RHD patients and participate in the National Registry of RF/RHD maintained by the Philippine Heart Association and the Philippine Foundation for RF/RHD Prevention and Control. For standardization, the contents of the EMR shall be set by PhilHealth and the reference HCI in collaboration with experts and stakeholders. While the contracted HCI is setting up an electronic recording of their RF/RHD patients, a logbook shall be allowed only on the first year of contract and provided that it reflects the required data fields set in the EMR.



h. All RF/RHD patients shall be monitored and tracked for relevant patient outcomes and other indicators set by the Corporation.

5. Claims Filing and Reimbursement

   a. The contracted HCI can file a claim for reimbursement only for approved pre-authorization requests and after rendering all mandatory services that are specified in Section VII, Table 1 of this Circular.

b. The claims application filed by the contracted HCI should include the following documents:

i. Transmittal Form of claims for the outpatient benefit package for RF/RHD (Annex "H") per claim or per batch of claims;

ii. Documentary attachments for all claims application for the outpatient benefit package for RF/RHD:

ii.1 Photocopy of the approved Pre-authorization Checklist and Request (Annex "A");

ii.2 PhilHealth Benefit Eligibility Form (PBEF) printout or its equivalent (e.g. Claim Form 1 or CF1) as proof of membership eligibility ;

ii.3 Photocopy of the properly accomplished ME Form (Annex "B") for tranche 1 claim application.

Note: A copy of the properly accomplished ME Form shall be provided to the patient by the contracted HCI and the signed original copy should be attached to the patient's chart as a permanent record.

iii. Properly accomplished PhilHealth Claim Form 2 (CF2) (Annex "I");

iv. Checklist of Mandatory Services and Other Services (Annex "C1" and "C2");

v. RF/RHD Satisfaction Questionnaire (Annex "D");

Note: The satisfaction questionnaire should reflect the feedback of the patient on the services rendered for every tranche.

vi. Checklist of Requirements for Reimbursement (Annex "E")

c. Rules on late filing shall apply.

d. If the delay in the filing of claims is due to natural calamities or other fortuitous events, the contracted HCI shall be accorded an extension period of 60 calendar days as stipulated in Section 47 of the Implementing Rules and Regulations (IRR) of the National Health Insurance Act of 2013 (Republic Act 7875, as amended).

e. There shall be no direct filing of claims by members.

f. A filed claim shall undergo review for the completeness of all forms submitted. Signatures of the attending PhilHealth accredited doctor and

the Medical Director/Medical Center Chief and the RF/RHD Coordinator, who are attesting that all the mandatory services were provided to the patient, are required;

g. There shall be NO Return to Sender (RTS). It is the contracted HCI's responsibility to make sure that all documents are completely filled out and in order prior to submission of claims application to PhilHealth. The PROs and LHIOs have the prerogative not to accept incomplete documents. However, the PRO/ LHIO staff should directly coordinate with the contracted HCIs when there are deficiencies in the documents filed. Once the documents are complete, the contracted HCI can file the claims application to PhilHealth for reimbursement within the required filing schedule.

h. All claims application submitted by the contracted HCI shall be processed by PhilHealth within 30 working days from receipt of claim provided that all requirements are fulfilled by the contracted HCI. (Refer to Annex "E" for the checklist of requirements for reimbursement).

i. Payment for claims shall be denied only in the following instances:

   i. If a mandatory service was not provided by the contracted HCI;

   ii. If the required signatures in the forms are missing;

   iii. Incompletely filled out forms;

   iv. Incomplete attachments, such as ME Form, photocopy of the approved Pre-authorization Checklist and Request, and other forms required under the benefit package;

   v. Late filing.

j. The contracted HCI may apply for motion for reconsideration for all denied claims based on existing PhilHealth policies.

k. All claims shall be paid directly to the contracted HCI.

l. In the event that the patient expires in the course of treatment or the patient is lost to follow up (as defined in Section V. Item B), the contracted HCI may still file claims for the payment of mandatory services rendered to the patient. The contracted HCI should submit a notarized sworn declaration for patients who expired or are declared lost to follow up.

The following antibiotic prophylaxis should have been completed by the expired patient for claims reimbursement:

i. For 21-day secondary prophylaxis: completed at least 6 injections of penicillin G benzathine (benzathine benzylpenicillin)

ii. For 28-day secondary prophylaxis: completed at least 4 injections of penicillin G benzathine (benzathine benzylpenicillin)

iii. For secondary oral prophylaxis: completed at least 6 months of oral intake of phenoxymethyl penicillin (penicillin V) (as potassium salt) or erythromycin

The sworn declaration should describe the number of injections or oral secondary prophylaxis completed by the patient.

m. Patient transfer

i. RF/RHD patients who wish to transfer to another contracted HCI shall express their intention by accomplishing the Letter of Intent for transfer of RF/RHD care to a Referral RF/RHD provider (Annex "G") in triplicate, to be to submitted to the following:

- referring RF/RHD provider
- referral RF/RHD provider
- Benefits Administration Section of the PhilHealth Regional Office whose jurisdiction is within the referring RF/RHD provider

The RF/RHD Coordinator should guide the patient in accomplishing the form.

Transfer to another facility is allowed only after completing the services for tranche 1 (Section VI. Item C.4, Table 2).

ii. RF/RHD patients who shall transfer to other contracted RF/RHD providers are required to have a Checklist for Patient Transfer (Annex "M") properly accomplished by their referring contracted RF/RHD provider to be submitted to the referral RF/RHD provider. The referral RF/RHD provider should be notified in advance by the referring RF/RHD provider of the plans to transfer a RF/RHD patient.

D. MONITORING AND POLICY REVIEW

Contracted HCIs shall be monitored for compliance to the contract and to the standards of the benefit package during implementation. The EMR is intended to facilitate tracking of patients and reporting and analysis of patient level data by both PhilHealth and the contracted HCI.

Conduct of field monitoring shall be scheduled by PhilHealth to monitor service provision by contracted HCI as well as gather patient feedback. The performance indicators and measures to monitor compliance to the policies of this Circular shall be established in collaboration with relevant stakeholders and experts. This shall be incorporated in the appropriate issuance pertinent to monitoring.

Reports and results of field monitoring visits shall be inputs and shall inform the regular policy review.

E. MARKETING, PROMOTION AND PATIENT EMPOWERMENT

In order to educate the general public and increase their awareness on the outpatient benefit package for the secondary prevention of RF/RHD and to promote informed decision-making and participation among patients, health care professionals, and health care institutions, and other stakeholders, marketing and promotional activities shall be undertaken in accordance with the integrated marketing and communication plan of PhilHealth.

The Corporation shall likewise undertake regular monitoring and evaluation of the effectiveness of the marketing and promotion activities of the benefit package. Further, patients and stakeholders shall be given the opportunity to participate and contribute to the improvement of marketing and promotional activities of the Corporation that are pertinent to this benefit.

VII. REPEALING CLAUSE

Provisions of previous issuances inconsistent with this Circular are hereby amended, modified or repealed accordingly. Those that are consistent shall remain valid and binding.

VIII. EFFECTIVITY

This circular shall take effect fifteen (15) days after publication in a newspaper of general circulation and shall be deposited with the National Administrative Register, University of the Philippines Law Center.

IX. ANNEXES (Annexes shall be uploaded in the PhilHealth website)

A. Pre-authorization Checklist and Request (Annex "A")
B. ME Form (Annex "B")
C. Checklist of Mandatory Services and Other Services (Annex "C")
D. RF/RHD Satisfaction Questionnaire (Annex "D")
E. Checklist of Requirements for Reimbursement (Annex "E")
F. HCI Standards as Providers for the Outpatient Benefit Package for RF/RHD (Annex "F")
G. Letter of Intent for transfer of RF/RHD care to a Referral RF/RHD provider (Annex "G")
H. Transmittal Form (Annex "H")
I. Sample Claim Form 2 (Annex "I")
J. Checklist of indications for oral secondary prophylaxis (Annex "J")
K. General process flow for the provision of care for RF/RHD (Annex "K")
L. Checklist of services that may be outsourced by the contracted HCI (Annex "L")
M. Checklist for Patient Transfer (Annex "M")
N. OPD Assessment Form (Annex "N")
O. Registry Form for Diagnosed Cases (Annex "O")
P. Clinical Pathway for the Rheumatic Fever Suspect (Annex "P)

ROY B. FERRER, MD, MSc
Acting President and CEO

Date Signed: 02/27/19

MASTER COPY
DC: mjs Date: 3/27/19

Subject: Outpatient Benefit Package for the Secondary Prevention of Rheumatic Fever/Rheumatic Heart Disease

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Case No. _____

Annex "A – RF/RHD"

HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER (answer only if the patient is a dependent)	1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

Fulfilled selections criteria ☐ **Yes** If yes, proceed to pre-authorization application
☐ **No** If no, specify reason/s and encode _____

PRE-AUTHORIZATION CHECKLIST
Rheumatic Fever/Rheumatic Heart Disease

QUALIFICATION		
Place a check mark (✓) for the Stage of the Disease	Stage: ☐ A ☐ B	☐ C ☐ D

Fulfills any of the following criteria:

Echocardiogram finding (tick one, whichever is applicable):	Date/s of 2D-echo
☐ Fulfills Modified Jones Criteria Normal to Stage A valve involvement	
☐ Definite RHD Echo Stage B Progressive Valve Disease Normal LV size and function	
☐ Definite RHD Stage C Moderate to severe valve involvement Left ventricle enlargement No heart failure Functional Class I-II	

MASTER COPY Date: 3/27/19 DC: MJS

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PRE-AUTHORIZATION REQUEST
Rheumatic Fever/Rheumatic Heart Disease

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the outpatient benefit package for the secondary prevention of RF/RHD

_____ in _____
(NAME OF PATIENT) (NAME OF HCI)
under the terms and conditions as agreed for availment of the said benefit package.

The patient belongs to the following category (please tick appropriate box):

☐ No Balance Billing (NBB)
☐ Co-pay

Certified correct by:	Certified 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.

Conforme by:

(Printed name and signature)
Parent/Guardian

MASTER COPY Date: 3/27/19 DC: ays

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

_____
(Printed name and signature)
Authorized Personnel, Benefits Administration Section (BAS)

INITIAL APPLICATION		
Activity	**Initial**	**Date**
Received by LHIO/BAS:		
Endorsed to BAS (if received by LHIO):		
☐ Approved ☐ Disapproved		
Released to HCI:		
This pre-authorization is valid within 12 months from date of approval of request.		

COMPLIANCE TO REQUIREMENTS		
☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Activity	**Initial**	**Date**
Received by BAS:		
☐ Approved ☐ Disapproved		
Released to HCI:		

Echocardiogram finding (Continuation)	Date/s of 2D-echo
☐ Definite RHD Stage D Severe valve involvement or multiple Left ventricle enlargement With heart failure Functional Class III-IV	
Treatment Plan: choose one	
☐ Secondary prevention intramuscular, Penicillin G benzathine (benzathine benzylpenicillin)	Choose one ☐ every 21 days ☐ every 28 days
OR	
☐ Secondary prophylaxis with oral medication	Choose one ☐ phenoxymethyl penicillin (penicillin V) ☐ erythromycin

Certified correct by Attending Physician:

Printed name and signature

PhilHealth Accreditation No. ☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐

Note:
Once approved, the contracted HCI shall print the approved pre-authorization form and have this signed by the parent or guardian and health care providers, as applicable. This form shall be submitted to the PhilHealth Regional Office (PRO) or the Local Health Insurance Office (LHIO) when filing the first tranche.
There is no need to attach laboratory results. However, these should be included in the patient's chart and may be checked during the field monitoring of the RF/RHD Benefits. Please do not leave any item blank.

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Numero ng kaso: _____
Case No.

Annex "B-ME Form"

MEMBER EMPOWERMENT FORM

Magpaalám, tumulong, at magbigay kapangyarihan
Inform, Support & Empower

Mga Panuto:
Instructions:
Ang dokumentong ito ay nasusulat sa dalawang wika:
This document is written in two languages:

1. Ipaliliwanag at tutulungan ng kinatawan ng ospital ang pasyente sa pagsasagot ng ME form.
   The health care provider shall explain and assist the patient in filling-up the ME form.

2. Isulat nang maayos at malinaw ang mga impormasyon na kinakailangan.
   Legibly print all information provided.

3. Para sa mga katanungang nangangailangan ng sagot na "oo" o "hindi", lagyan ng marka (✓) ang angkop na kahon.
   For items requiring a "yes" or "no" response, tick appropriately with a check mark (✓).

4. Gumamit ng karagdagang papel kung kinakailangan . Lagyan ito ng kaukulang marka at ilakip ito sa ME form.
   Use additional blank sheets if necessary, label properly and attach securely to this ME form.

5. Ang kinontratang ospital na magkakaloob ng dalubhasang pangangalaga sa pagpaparami ng kopya ng ME Form.
   The ME form shall be reproduced by the contracted health care institution (HCI) providing specialized care.

6. Tatlong kopya ng ME form ang kailangang ibigay ng kinontratang ospital. Ang mga kopyang nabanggit ay ilalaan para sa pasyente, ospital at PhilHealth.
   Triplicate copies of the ME form shall be made available by the contracted HCI—one for the patient; one as file copy of the contracted HCI providing the specialized care and one for PhilHealth.

PANGALAN NG OSPITAL *HEALTH CARE INSTITUTION (HCI)*
ADRES NG OSPITAL *ADDRESS OF HCI*

MASTER COPY
Date: 3/27/19
DC: MJS

A. Impormasyon ng Miyembro/ Pasyente
A. Member/Patient Information

MIYEMBRO (kung ang pasyente ay kalipikadong makikinabang) (Apelyido, Pangalan, Panggitnang Apelyido, Karagdagan sa Pangalan)
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)

NUMERO NG PHILHEALTH ID NG **MIYEMBRO** ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐☐

PERMANENTENG TIRAHAN
PERMANENT ADDRESS

PANSAMANTALANG TIRAHAN
TEMPORARY ADDRESS

PASYENTE (Apelyido, Pangalan, Panggitnang Apelyido, Karagdagan sa Pangalan)
PATIENT (Last name, First name, Middle name, Suffix

NUMERO NG PHILHEALTH ID NG **PASYENTE** ☐☐ — ☐☐☐☐☐☐☐☐☐ — ☐☐
PHILHEALTH ID NUMBER OF PATIENT

PERMANENTENG TIRAHAN
PERMANENT ADDRESS

PANSAMANTALANG TIRAHAN
TEMPORARY ADDRESS

Petsa ng Kapanganakan (Buwan/Araw/Taon) *Birthday (mm/dd/yyyy)*	Edad *Age*	Kasarian *Sex*
Numero ng Telepono *Telephone Number*	Numero ng Cellphone *Mobile Number*	Email Address *Email Address*

Kategorya bilang Miyembro:
Membership Category:

☐ Empleado sa
Employed Sector
- ☐ Gobyerno
  Government
- ☐ Pribado
  Private
  - ☐ May-ari ng Kompanya / *Enterprise Owner*
  - ☐ Kasambahay / *Household Help*
  - ☐ Tagamaneho ng Pamilya/ *Family driver*

☐ *Self Employed*
- ☐ Filipinong Manggagawa sa ibang bansa
  Migrant Worker/ OFW
- ☐ Informal Sector / May sariling pinagkakakitaan (Halimbawa. Negosyante, Nagmamaneho ng traysikel at taxi, mga propesyonal, artista, at iba pa)
  Informal Sector / Self-Earning Individuals (Ex. Business owner/ tricycle/ taxi drivers/ street vendors, entrepreneurs, professionals, artists, etc.)
- ☐ Filipino na may dalawang pagkamamamayan/ *Naturalized Filipino Citizen*
  Filipino with Dual Citizenship/ Naturalized Filipino Citizen
- ☐ *Organized Group* ☐ *IGroup Gold*

☐ Marálitâ
Indigent (4Ps/ CCT, MCCT)

☐ Inisponsuran
Sponsored
- ☐ Bayan | *LGU*
- ☐ Nakatatandang mamamayan | *Senior Citizen* (RA 10645)
- ☐ Iba pa | *Others*

☐ Habambuhay na kaanib/ Lifetime Member

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B. Impormasyong Klinikal *B. Clinical Information*	
1. Paglalarawan ng kondisyon ng pasyente *Description of condition*	
2. Napagkasunduang angkop na plano ng gamutan sa ospital *Applicable Treatment Plan agreed upon with healthcare provider*	
3. Napagkasunduang angkop na alternatibong plano ng gamutan sa ospital *Applicable alternative Treatment Plan agreed upon with health care provider*	
C. Talatakdaan ng Gamutan at Kasunod na Konsultasyon ***C. Treatment Schedule and Follow-up Visit/s***	
1. Petsa ng unang pagkakaospital o konsultasyon [a] (buwan/araw/taon) *Date of initial admission to HCI or consult[a] (mm/dd/yyyy)* [a] For ZMORPH, this refers to the external lower limb pre-prosthesis rehabilitation consult. For PD First, this refers to the date of medical consultation or visit to the PD Provider prior to the start of the first PD exchange. For RF/RHD, this refers to the date of 1st check-up.	
2. Pansamantalang Petsa ng susunod na pagpapa-ospital o konsultasyon[b] (buwan/araw/taon) *Tentative Date/s of succeeding admission to HCI or consult[b] (mm/dd/yyyy)* [b] For ZMORPH, this refers to the external lower limb measurement, fitting and adjustments For the PD First, this refers to the next visit to the PD Provider. For RF/RHD, this refers to the date of first injection.	
3. Pansamantalang Petsa ng kasunod na pagbisita [c] (buwan/araw/taon) *Tentative Date/s of follow-up visit/s (mm/dd/yyyy)* [c] For ZMORPH, this refers to the external lower limb post-prosthesis rehabilitation consult. For RF/RHD, this refers to the dates of succeeding injections.	Date of succeeding injections

D. Edukasyon ng Miyembro *D. Member Education*		
Lagyan ng tsek (✓) ang angkop na sagot o NA kung hindi nauukol *Put a check mark (✓) opposite appropriate answer or NA if not applicable.*	OO *YES*	HINDI *NO*
1. Ipinaliwanag ng kinatawan ng ospital ang uri ng aking karamdaman. *My health care provider explained the nature of my condition.*		
2. Ipinaliwanag ng kinatawan ng ospital ang mga pagpipiliang paraan ng gamutan/interbensyon [d] *My health care provider explained the treatment options/intervention[d].*		
3. Ipinaliwanag ng kinatawan ng ospital ang mga posibleng mga epekto/ masamang epekto ng gamutan/ interbensyon. *The possible side effects/adverse effects of treatment/intervention were explained to me.*		
4. Ipinaliwanag ng kinatawan ng ospital ang kailangang serbisyo para sa gamutan ng aking karamdaman/ interbensyon. *My health care provider explained the mandatory services and other services required for the treatment of my condition/intervention.*		
5. Lubos akong nasiyahan sa paliwanag na ibinigay ng ospital. *I am satisfied with the explanation given to me by my health care provider*		
6. Naibigay sa akin nang buo ang impormasyon na ako ay mahusay na aalagaan ng mga dalubhasang doktor sa aking piniling kinontratang ospital ng PhilHealth at kung gustuhin ko mang lumipat ng ospital ay hindi ito maka-aapekto sa aking pagpapagamot. *I have been fully informed that I will be cared for by all the pertinent medical and allied specialties, as needed, present in the PhilHealth contracted HCI of my choice and that preferring another contracted HCI for the said specialized care will not affect my treatment in any way.*		
7. Ipinaliwanag ng kinatawan ng ospital ang kahalagahan ng pagsunod sa panukalang gamutan/interbensyon. Kasama rito ang pagkompleto ng gamutan/interbensyon sa unang ospital kung saan nasimulan ang aking gamutan/interbensyon. *My health care provider explained the importance of adhering to my treatment plan/intervention. This includes completing the course of treatment/intervention in the contracted HCI where my treatment/intervention was initiated.* Paalala: Ang hindi pagsunod ng pasyente sa napagkasunduang gamutan/interbensyon sa ospital ay maaaring magresulta sa hindi pagbabayad ng mga kasunod na claims at hindi dapat itong ipasa bilang case rates. *Note: Non-adherence of the patient to the agreed treatment plan/intervention in the HCI may result to denial of filed claims for the succeeding tranches and which should not be filed as case rates.*		
Bibigyan ako ng ospital ng talaan ng mga susunod kong pagbisita. *My health care provider gave me the schedule/s of my follow-up visit/s.*		

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D. Edukasyon ng Miyembro *D. Member Education* Lagyan ng tsek (✓) ang angkop na sagot o NA kung hindi nauukol *Put a check mark (✓) opposite appropriate answer or NA if not applicable.*	OO YES	HINDI NO
9. Ipinaalam sa akin ng ospital ang impormasyon tungkol sa maaari kong hingan ng tulong pinansiyal o ibang pang suporta, kung kinakailangan. a. Sangay ng pamahalaan (Hal.: PCSO, PMS, LGU, etc.) b. Civil society o non-government organization c. Patient Support Group d. Corporate Foundation e. Iba pa (Hal. Media, Religious Group, Politician, etc.) *My health care provider gave me information where to go for financial and other means of support, when needed.* *a. Government agency (ex. PCSO, PMS, LGU, etc.)* *b. Civil society or non-government organization* *c. Patient Support Group* *d. Corporate Foundation* *e. Others (ex. Media, Religious Group, Politician, etc.)*		
10. Nabigyan ako ng kopya ng listahan ng mga kinontratang ospital para sa karampatang paggagamot ng aking kondisyon o karamdaman. *I have been furnished by my health care provider with a list of other contracted HCIs for the specialized care of my condition.*		
11. Nabigyan ako ng sapat na kaalaman hinggil sa benepisyo at tuntunin ng PhilHealth sa pagpapa-miyembro at paggamit ng benepisyong naaayon sa PhilHealth benefit package: *I have been fully informed by my health care provider of the PhilHealth membership policies and benefit availment on the PhilHealth benefit package:* a. Kaalipikado ako sa mga itinakdang batayan para sa aking kondisyon/kapansanan. *I fulfill all selections criteria for my condition/ disability.*		
b. Ipinaliwanag sa akin ang polisiya hinggil sa "No Balance Billing" (NBB) *The "no balance billing" (NBB) policy was explained to me.* Paalala: Ang polisiya ng NBB ay maaaring makamit ng mga sumusunod na miyembro at kanilang kalipikadong makikinabang kapag na-admit sa ward ng ospital: inisponsuran, maralita, kasambahay, senior citizens at miyembro ng iGroup na may kaukulang Group Policy Contract (GPC) *Note: NBB policy is applicable to the following members when admitted in ward accommodation: sponsored, indigent, household help, senior citizens and iGroup members with valid Group Policy Contract (GPC) and their qualified dependents.*		
Para sa inisponsuran, maralita, kasambahay, senior citizens at miyembro ng iGroup na may kaukulang Group Policy Contract (GPC) at kanilang kwalipikadong makikinabang, sagutan ang c, d at e. ***For sponsored, indigent, household help, senior citizens and iGroup members with valid GPC and their qualified dependents, answer c, d and e.*** c. Nauunawaan ko na sakaling hindi ako gumamit ng NBB ay maaari akong magkaroon ng kaukulang gastos na aking babayaran. *I understand that I may choose not to avail of the NBB and may be charged out of pocket expenses*		

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D. Edukasyon ng Miyembro *D. Member Education*		
Lagyan ng tsek (✓) ang angkop na sagot o NA kung hindi nauukol *Put a check mark (✓) opposite appropriate answer or NA if not applicable.*	OO YES	HINDI NO
d. Sakaling ako ay magpapalipat sa mas magandang kuwarto ayon sa aking kagustuhan, nauunawaan ko na hindi na ako maaaring humiling sa pagamutan para makagamit ng pribilehiyong ibinibigay sa mga pasyente na NBB (kapag NBB, wala nang babayaran pa pagkalabas ng pagamutan) *In case I choose to upgrade my room accommodation, I understand that I can no longer demand the hospital to grant me the privilege given to NBB patients (that is, no out of pocket payment upon discharge from the hospital)* e. Ninanais ko na lumabas sa polisiyang NBB ang PhilHealth at dahil dito, babayaran ko ang anumang halaga na hindi sakop ng benepisyo sa PhilHealth *I opt out of the NBB policy of PhilHealth and I am willing to pay on top of my PhilHealth benefits* f. Pumapayag akong magbayad ng hanggang sa halagang PHP _____* para sa: *I agree to pay as much as PHP _____* for the following:* ☐ anumang karagdagang serbisyo, tukuyin _____ *additional services, specify* _____ * Ito ay tinantiyang halaga lamang na gagabay sa pasyente kung magkano ang kanyang babayaran at hindi dapat gawing batayan para sa pagtutuos ng kuwenta ng nagugol na gastusin sa pagkakaospital na babayaran ng PhilHealth. *This is an estimated amount that guides the patient on how much the out of pocket may be and should not be a basis for auditing claims reimbursement.*		
Ang mga sumusunod na katanungan ay para sa mga miyembro ng formal at informal economy at kanilang mga kalipikadong makikinabang ***The following are applicable to formal and informal economy and their qualified dependents*** g. Naiintindihan ko na maaari akong magkaroon ng babayaran para sa halagang hindi sakop ng benepisyo sa PhilHealth. *I understand that there may be an additional payment on top of my PhilHealth benefits.* h. Pumapayag akong magbayad ng hanggang sa halagang PHP _____* para sa aking gamutan na hindi sakop ng benepisyo ng PhilHealth. *I agree to pay as much as PHP _____* as additional payment on top of my PhilHealth benefits.* * Ito ay tinantiyang halaga lamang na gagabay sa pasyente kung magkano ang kanyang babayaran at hindi dapat gawing batayan para sa pagtutuos ng kuwenta ng nagugol na gastusin sa pagkakaospital na babayaran ng PhilHealth. *This is an estimated amount that guides the patient on how much the out of pocket may be and should not be a basis for auditing claims reimbursement.*		
12. Limang (5) araw lamang ang babawasan mula sa 45 araw na palugit sa benepisyo sa isang taon para sa buong gamutan sa ilalim ng benefit package na ito. *Only five (5) days shall be deducted from the 45 confinement days benefit limit per year for the duration of my treatment/intervention under this benefit package.*		

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E. Tungkulin at Responsabilidad ng Miyembro *E. Member Roles and Responsibilities* Lagyan ng (✓) ang angkop na sagot o NA kung hindi nauukol *Put a (✓) opposite appropriate answer or NA if not applicable.*	OO *YES*	HINDI *NO*
1. Nauunawaan ko ang aking tungkulin upang masunod ang nararapat at nakatakda kong gamutan. *I understand that I am responsible for adhering to my treatment schedule.*		
2. Nauunawaan ko na ang pagsunod sa itinakdang gamutan ay mahalaga tungo sa aking paggaling at pangunahing kailangan upang magamit ko nang buo ang benefit package na ito *I understand that adherence to my treatment schedule is important in terms of clinical outcomes and a pre-requisite to the full entitlement of this benefit package.*		
3. Nauunawaan ko na tungkulin kong sumunod sa mga polisiya at patakaran ng PhilHealth at ospital upang magamit ang buong benefit package na ito. Kung sakali na hindi ako makasunod sa mga polisiya at patakaran ng PhilHealth at ospital, tinatalikuran ko ang aking pribilehiyong makagamit ng benefit package na ito. *I understand that it is my responsibility to follow and comply with all the policies and procedures of PhilHealth and the health care provider in order to avail of this full benefit package. In the event that I fail to comply with policies and procedures of PhilHealth and the health care provider, I waive the privilege of availing this benefit package.*		

F. Pangalan, Lagda, Thumb Print at Petsa *F. Printed Name, Signature, Thumb Print and Date*		
_____ Pangalan at Lagda ng pasyente/parent/guardian:* *Printed name and signature of patient** *Para sa mga menor de edad, ang magulang o tagapag-alaga ang pipirma o maglalagay ng thumb print sa ngalan ng pasyente. * *For minors, write the printed name and affix the signature of the parent or guardian on behalf of the patient.*	Thumb Print (kung hindi makakasulat ang pasyente) *(if patient is unable to write)*	Petsa (buwan/ araw/ taon)
_____ Pangalan at lagda ng nangangalagang Doktor: *Printed name and signature of Attending Doctor*		Petsa (buwan/araw/taon) *Date (mm/ dd/ yyyy)*
Mga Saksi: *Witnesses:*		
_____ Pangalan at lagda ng kinatawan ng ospital: *Printed name and signature of HCI staff member*		Petsa (buwan/araw/taon) *Date (mm/ dd/ yyyy)*
_____ Pangalan at lagda ng asawa/ magulang / pinakamalapit na kamag-anak/awtorisadong kinatawan (Bilugan ang relasyon sa pasyente) *Printed name and signature of spouse/ parent/ next of kin / authorized guardian or representative* ☐ walang kasama/ *no companion*		Petsa (buwan/araw/taon) *Date (mm/ dd/ yyyy)*

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H. Numerong maaaring tawagan sa PhilHealth
H. PhilHealth Contact Details

Opisinang Panrehiyon ng PhilHealth _____
PhilHealth Regional Office No.
Numero ng telepono _____
Hotline Nos.

I. Guhit ng Tirahan at Palatandaan
I. Sketch of Home Address with Landmark

Bilang bahagi ng patuloy na pagpapabuti ng PhilHealth sa pagbigay ng mga benepisyo at serbisyo, ibinibigay ko ang mga sumusunod na impormasyon para sa pagbisita sa mga tahanan ng mga nakinabang sa Z Benefits: (Pakiguhit ang inyong tirahan sa ibaba.)

As part of the continuing efforts of PhilHealth to improve the benefits delivery and services, I am providing the following information for the sole purpose of conducting home visits to patients who availed of the Z Benefits: (Please draw a sketch of your home address below.)

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Landmark/s: _____

Nearest National Road (as applicable): _____

Nearest Church, School or Establishment (if any): _____

Nearest Barangay Hall: _____

Other information to guide directions to your home: _____

J. Pahintulot sa pagsusuri sa talaan ng pasyente *J. Consent to access patient record*	K. Pahintulot na mailagay ang *medical data* sa RF/RHD Registry *K. Consent to enter medical data in the RF/RHD Registry*
Ako ay pumapayag na suriin ng PhilHealth ang aking talaang medikal upang mapatunayan ang katotohanan ng claim na isinumite. *I consent to the examination by PhilHealth of my medical records for the sole purpose of verifying the veracity of the claim submitted.*	Ako ay pumapayag na mailagay ang aking impormasyong medikal sa RF/RHD Registry na kailangan sa benefit package na ito. Pinahihintulutan ko din ang PhilHealth na maipaalam ang aking personal na impormasyong pangkalusugan sa mga kinontratang ospital. *I consent to have my medical data entered electronically in the RF/RHD Registry as a requirement for the this benefit package. I authorize PhilHealth to disclose my personal health information to its contracted partners*

Ako ay nagpapatunay na walang pananagutan ang PhilHealth o sinumang opisyal, empleyado o kinatawan mula sa pahintulot na nakasaad sa itaas sapagkat kusang-loob ko itong ibinigay upang makagamit ng benefit packages ng PhilHealth.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with the claim/s for reimbursement before PhilHealth.

Buong pangalan at lagda ng pasyente* *Printed name and signature of patient** * Para sa mga menor de edad, ang magulang o tagapag-alaga ang pipirma o maglalagay ng thumb print sa ngalan ng pasyente. * *For minors, the parent or guardian affixes their signature or thumb print here on behalf of the patient.*	Thumb print (Kung hindi na makasusulat) *(if patient is unable to write)*	Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*
Buong pangalan at lagda ng kumakatawan sa pasyente *Printed name and signature of patient's representative* ☐ walang kasama/ *no companion*		Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*

Relasyon ng kumakatawan sa pasyente (Lagyan ng tsek ang angkop na kahon)
Relationship of representative to patient (tick appropriate box)

☐ asawa *spouse* ☐ magulang *parent* ☐ anak *child* ☐ kapatid *next of kin* ☐ tagapag-alaga *guardian* ☐ walang kasama *no companion*

L. Detalye ng Tagapag-ugnay ng PhilHealth para sa RF/RHD outpatient benefit package
L. PhilHealth RF/RHD Coordinator Contact Details

Pangalan ng Tagapag-ugnay ng PhilHealth para sa RF/RHD benefit package na ito na nakatalaga sa ospital
Name of PhilHealth RF/RHD Coordinator assigned at the HCI

Numero ng Telepono *Telephone number*	Numero ng CellPhone *Mobile number*	Email Address

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Call Center (02) 441-7442 Trunkline (02) 441-7444
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Case No. _____

Annex "C1 – RF/RHD"

CHECKLIST OF MANDATORY AND OTHER SERVICES
Rheumatic Fever/Rheumatic Heart Disease

Tranche 1

HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER (answer only if the patient is a dependent)	1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

	MANDATORY SERVICES	Status
A. For rheumatic fever	Tick one, whichever is applicable ☐ penicillin G benzathine (benzathine benzylpenicillin), 1.2M units, vial (MR) (IM) every 28 days OR	Dates of injection: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____
	☐ Oral secondary prophylaxis, tick one ☐ phenoxymethyl penicillin (penicillin V) ☐ erythromycin	Start date of oral prophylaxis: _____ Date of last intake: _____

OTHER SERVICES, as needed	Status
[redacted]	

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	MANDATORY SERVICES	Status
B. For RF/RHD	Tick one, whichever is applicable ☐ penicillin G benzathine (benzathine benzylpenicillin) , 1.2M units, vial (MR) (IM) every 21 days OR	Dates of injection: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____
	☐ Oral secondary prophylaxis, tick one ☐ phenoxymethyl penicillin (penicillin V) ☐ erythromycin	Start date of oral prophylaxis: _____ Date of last intake: _____
C. Laboratory exam	[redacted]	
D. Others	[redacted]	
E.	Date of initial registration in the RF/RHD Registry	Date

OTHER SERVICES, as needed	Status
[redacted]	
	Indicate date/s done or NA if not applicable
☐ ASO	
☐ ESR	
☐ CRP	
☐ CBC with platelet	
☐ EKG	
☐ Chest X-ray	
aspirin	
prednisone	
antacid	
[redacted]	

Conforme by	Documents reviewed by
(Printed name and signature) Parent/Guardian/Patient	(Printed name and signature) RF/RHD Coordinator
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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Certified correct by:	Certified 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)

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Annex "C2 – RF/RHD"

CHECKLIST OF MANDATORY AND OTHER SERVICES
Rheumatic Fever/Rheumatic Heart Disease

Tranche 2

HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER (answer only if the patient is a dependent)	1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

	MANDATORY SERVICES	Status
A. For rheumatic fever	Tick one, whichever is applicable ☐ penicillin G benzathine (benzathine benzylpenicillin), 1.2M units, vial (MR) (IM) every 28 days OR	Dates of injection: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____
	☐ Oral secondary prophylaxis, tick one ☐ phenoxymethyl penicillin (penicillin V) ☐ erythromycin	Start date of oral prophylaxis: _____ Date of last intake: _____

OTHER SERVICES, as needed	Status
[redacted]	
[redacted]	

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	MANDATORY SERVICES	Status
B. For RF/RHD	Tick one, whichever is applicable ☐ penicillin G benzathine (benzathine benzylpenicillin) , 1.2M units, vial (MR) (IM) every 21 days OR	Dates of injection: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____
	☐ Oral secondary prophylaxis, tick one ☐ phenoxymethyl penicillin (penicillin V) ☐ erythromycin	Start date of oral prophylaxis: _____ Date of last intake: _____
C. Lab exam	2D Echocardiography	Date/s:
D. Others		
E.	Date/s of updates* in the RF/RHD Registry	Date/s

OTHER SERVICES, as needed	Status
	Place a check if given or NA if not applicable
aspirin	
prednisone	
antacid	

* The RF/RHD Coordinator should update the information of the patient in the registry at least every six months.

Conforme by	Documents reviewed by
(Printed name and signature) Parent/Guardian/Patient	(Printed name and signature) RF/RHD Coordinator
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Certified correct by:	Certified 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)

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Share your opinion with us!

We would like to know how you feel about the services that pertain to the outpatient benefit package for the secondary prevention of rheumatic fever/rheumatic heart disease 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

4. How would you rate the patient's or family's involvement in the care in terms of patient empowerment? (You may refer to your Member Empowerment Form)
   - ☐ excellent
   - ☐ satisfactory
   - ☐ unsatisfactory
   - ☐ don't know

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

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

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

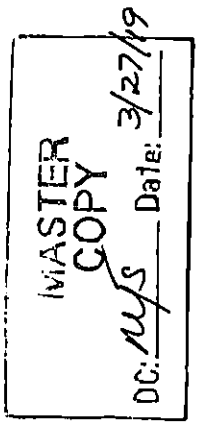
8. If you have other comments, please share them below:

   _____
   _____
   _____

Thank you. Your feedback is important to us!

_____
Signature of Patient/ Parent/ Guardian

Relationship to the patient: _____
Date accomplished: _____



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Annex "E – RF/RHD"

HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER (answer only if the patient is a dependent)	1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT
Rheumatic Fever/Rheumatic Heart Disease

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E-RF/RHD)	
2. Photocopy of approved Pre –Authorization Checklist & Request (Annex A- RF/RHD)	
3. Photocopy of completely accomplished ME FORM (Annex B) Note: ME Form is only required for tranche 1 claims application.	
4. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) at the time of pre-authorization application and CF 2	
5. Checklist of Mandatory and Other Services (Annex C- RF/RHD)	
6. Photocopy of completed Satisfaction Questionnaire (Annex D) Note: The satisfaction questionnaire should reflect the feedback of the patient on the services rendered for every tranche.	
DATE COMPLETED: (mm/dd/yyyy)	
DATE FILED: (mm/dd/yyyy)	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Parent/Guardian
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

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PHILHEALTH-PC 14 S.2015-F__

Self-assessment tool for the Outpatient Benefit Package for the Secondary Prevention of Rheumatic Fever/Rheumatic Heart Disease

Name of HCI: _____

Date of Survey (mm/dd/yyyy) : _____ Time started: _____Time ended:_____

Directions for the HCI:

1. Put a check (✓) under the HCI column if the standard is available and (✗) if not.
2. For outsourced services, put a (✓) under the HCI column and write under the remarks "outsourced:" plus the name of the outsourced service provider. Outsourced services, must have a Memorandum of Agreement (MOA) which reflects provisions for payment such as compliance to the No Balance Billing (NBB) Policy.
3. For proof of attendance to required course of training, certificates issued only by the Philippine Heart Association or its regional chapter will be accepted.

	REQUIREMENTS	HCI	PHIC	REMARKS
1	**HCI License and Accreditation**			
1.1	The HCI has an updated Department of Health (DOH) License to Operate (LTO)			
1.2	The HCI has an updated PhilHealth Accreditation			
2	**Mandatory Ancillary Services**			
2.1	**RF/RHD Direct - Observed Injection Clinic**			
a	Clean table surface with two chairs (one for the health care provider and the other for the patient)			
b	One examination bed to allow IM administration of the injection in a supine position			
c	A hand wash basin with soap, running water and paper towels			
d	Alcohol hand rub			
e	Emergency cart with epinephrine , IV hydrocortisone, IV fluids			
f	O_2 tank/ source with O_2 mask/ cannula			
2.2	Medications			
a	Benzathine penicillin injection 1.2M units/vial			
b	Oral phenoxymethylpenicillin (PCN-VK) 250 mg			
c	Erythromycin capsule 250mg / suspension			
3	**Human Resource**			
3.1	**At least 2 physicians (adult, pedia or family medicine, general practitioner with training)**			
a	Valid PRC license			
b	Valid PhilHealth accreditation			
c	Certificate of Completion of Training on the RF/RHD Implementation Guideline issued by the Philippine Heart Association or its regional chapter			

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	REQUIREMENTS	HCI	PHIC	REMARKS
3.3	**RF/RHD Coordinators**			
a	A registered nurse or midwife in charge of administering the injection			
	Certificate of Completion of Training on the RF/RHD Implementation Guideline issued by the Philippine Heart Association or its regional chapter			
b	Administrative Staff			
	with working knowledge on operation /process flow for RF/RHD who will be in-charge of record keeping and accomplishment of PhilHealth documents/forms			
	Certificate of Completion of Training on the RF/RHD Implementation Guideline issued by the Philippine Heart Association or its regional chapter			
3.4	**Available Forms / Recording**			
a	RF/RHD OPD Assessment Form			
b	RF/RHD OPD Secondary Prophylaxis Passport Book			
c	RF/RHD Registry Forms			
d	RF RHD manual entitled "OPLAN RF RHD: ASAP Awareness-Surveillance-Advocacy-Prevention" (Philippine Heart Association / Philippine Foundation of Prevention and Control of RF/RHD 2017)			

PhilHealth Survey Team

Surveyors' Names	Designation	Signature

HCI Management Team

Names of Management Team	Designation	Signature

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Agreements with HCI / Notes of PhilHealth after Pre-contracting survey

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Case No. _____

Annex "G – RF/RHD"

HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER (answer only if the patient is a dependent)	1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

LETTER OF INTENT FOR TRANSFER OF RF/RHD CARE TO A REFERRAL RF/RHD PROVIDER

This is to certify that I, _____ (Name of Patient), born on _____ (Date of Birth),

age _____ years old, residing at _____ (Address),

was diagnosed with rheumatic fever/rheumatic heart disease on _____ at the

_____ (Name of referring RF/RHD provider)

I am on (tick one):

- ☐ 21 day cycle penicillin G benzathine (benzathine benzylpenicillin) , 1.2M units and completed 10 injections
- ☐ 28 day cycle penicillin G benzathine (benzathine benzylpenicillin) , 1.2M units and completed 7 injection
- ☐ oral secondary antibiotic prophylaxis

I would like to request for transfer of RF/RHD care to _____ (Name of referral RF/RHD provider)

under the care of _____ (Name of Physician).

I understand that upon transfer to a referral RF/RHD provider, I will have to waive all my subsequent RF/RHD claims in my referring RF/RHD facility. In case I decide to return to the referring RF/RHD Center to resume my RF/RHD Care, I will have to abide by the policies set by them as a new RF/RHD patient.

Conforme by:	Certified correct by:
(Printed name and signature) Patient/ Parent/ Guardian	(Printed name and signature) Physician, Referring RF/RHD Center PhilHealth Accreditation No. ☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐

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Certified correct by:
(Printed name and signature) RF/RHD Coordinator, Referring RD/RHD Center

Acknowledged by:	Acknowledged by:
(Printed name and signature) BAS Head, PhilHealth Regional Office ____ in-charge of the referring HCI (to be returned to the referring HCI five working days upon receipt of the form)	(Printed name and signature) Head/PD Coordinator, Referral PD Center

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Kalusugan natin SEGURADO

Annex "H"

TRANSMITTAL FORM OF CLAIMS FOR THE OUTPATIENT BENEFITS FOR RF/RHD

NAME OF CONTRACTED HEALTH CARE INSTITUTION (HCI)	ADDRESS OF HCI

Instructions for filling out this Transmittal Form. Use additional sheets if necessary.
1. Use CAPITAL letters or UPPER CASE letters in filling out the form.
2. For the period of confinement, follow the format (mm/dd/yyyy).
3. For the Package Code, include the code for the order of tranche payment.
4. If the case number is available, indicate the case number in the first column.
5. The Remarks column may include some relevant notes which pertain to the filed claim that need to be relayed to PhilHealth.

Case Number	Name of Patient (Last, First, Middle Initial, Extension)	Period of Confinement		Package Code	Remarks
		Date admitted	Date discharged		
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

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Certified correct by authorized representative of the HCI		For PhilHealth Use Only	Initials	Date
	Designation	Received by Local Health Insurance Office (LHIO)		
Printed Name and Signature	Date signed (mm/dd/yyyy)	Received by the Benefits Administration Section (BAS)		

Annex "I-RF/RHD"

SAMPLE CLAIM FORM 2 FOR RHD (TRANCHE 1, 21-Day PRO LAXIS)

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email: actioncenter@philhealth.gov.ph

PhilHealth — Your Partner in Health

CF-2
(Claim Form 2)
Revised September 2018

Series # [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

IMPORTANT REMINDERS:
PLEASE WRITE IN CAPITAL **LETTERS** AND **CHECK** THE APPROPRIATE BOXES.
This form together with other supporting documents should be filed within sixty (60) calendar days from date of discharge.
All information, fields and tick boxes required in this form are necessary. Claim forms with incomplete information shall not be processed.
FALSE/INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.

PART I - HEALTH CARE INSTITUTION (HCI) INFORMATION

1. PhilHealth Accreditation Number (PAN) of Health Care Institution: H 9 3 0 0 X X X X

2. Name of Health Care Institution: PHILIPPINE HEART CENTER

3. Address: EAST AVENUE (Building Number and Street Name) — QUEZON CITY (City/Municipality) — (Province)

PART II - PATIENT CONFINEMENT INFORMATION

1. Name of Patient: DELA CRUZ (Last Name) — JUAN (First Name) — JR. (Name Extension (JR/SR/II)) — MASIPAG (Middle Name (or DELACRUZ JUAN JR SPAG))

2. Was patient referred by another Health Care Institution (HCI)?
☑ NO ☐ YES
Name of referring Health Care Institution | Building Number and Street Name | City/Municipality | Province | Zip code

3. Confinement Period:
a. Date Admitted 01-21-2019 (month-day-year) b. Time Admitted (hour:min) ☐ AM ☐ PM
c. Date Discharge 07-29-2019 (month-day-year) d. Time Discharge (hour:min) ☐ AM ☐ PM
OUTPATIENT

4. Patient Disposition: (select only 1)
☑ a. Improved
☐ b. Recovered
☐ c. Home/Discharged Against Medical Advise
☐ d. Absconded
☐ e. Expired (month-day-year) Time: (hour:min) ☐ AM ☐ PM
☐ f. Transferred/Referred — Name of Referral Health Care Institution
Reason/s for referral/transfer:

5. Type of Accomodation: ☐ Private ☐ Non-Private (Charity/Service)

6. Admission Diagnosis/es:
RF/RHD

7. Discharge Diagnosis/es (Use additional CF2 if necessary):

	Diagnosis	ICD-10 Code/s	Related Procedure/s (if there's any)	RVS Code	Date of Procedure	Laterality (check applicable box)
a.	RF/RHD		i.			☐ left ☐ right ☐ both
			ii.			☐ left ☐ right ☐ both
			iii.			☐ left ☐ right ☐ both
b.			i.			☐ left ☐ right ☐ both
			ii.			☐ left ☐ right ☐ both
			iii.			☐ left ☐ right ☐ both

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8. Special Considerations:
a. For the following repetitive procedures, tick box that applies and enumerate the procedure/sessions dates (mm-dd-yyyy). For chemotherapy, see guidelines.
☐ Hemodialysis ☐ Blood Transfusion
☐ Peritoneal Dialysis ☐ Brachytherapy
☐ Radiotherapy (LINAC) ☐ Chemotherapy
☐ Radiotherapy (COBALT) ☐ Simple Debridement
b. For Z-Benefit Package — **Z-Benefit Package Code:** RERHD_Tranche 1
c. For MCP Package (enumerate four dates [mm-dd-year] of pre-natal check-ups)
1 ____ 2 ____ 3 ____ 4 ____
d. For TB DOTS Package ☐ Intensive Phase ☐ Maintenance Phase
e. For Animal Bite Package (write the dates [mm-dd-year] when the following doses of vaccine were given) **Note: Anti Rabies Vaccine (ARV), Rabies Immunoglobulin (RIG)**
Day 0 ARV ____ **Day 3 ARV** ____ **Day 7 ARV** ____ **RIG** ____ **Others (Specify)** ____
f. For Newborn Care Package ☐ Essential Newborn Care ☐ Newborn Hearing Screening Test ☐ Newborn Screening Test
For Newborn Screening, *please attach NBS Filter Sticker here*
For Essential Newborn Care (check applicable boxes)
☐ Immediate drying of newborn ☐ Timely cord clamping ☐ Weighing of the newborn ☐ BCG vaccination ☐ Hepatitis B vaccination
☐ Early skin-to-skin contact ☐ Eye Prophylaxis ☐ Vitamin K administration ☐ Non-separation of mother/baby for early breastfeeding initiation
g. For Outpatient HIV/AIDS Treatment Package **Laboratory Number:** ____

9. PhilHealth Benefits:
ICD 10 or RVS Code: First Case Rate ____ Second Case Rate ____

Date of first injection for the specific tranche (refer to Table 2 of the circular)

Date of final injection for the specific tranche (refer to Table 2 of the circular)

Write OUTPATIENT in lieu of time admitted & discharged

Tick YES if the patient was referred by another HCI

This is not required as injection is administered in an out-patient setting

Indicate the diagnosis

Indicate the appropriate outpatient benefit package code "RFRHD" and order of tranche

This is not required

10. Accreditation Number/Name of Accredited Health Care Professional/Date Signed and Professional Fees/Charges
(Use additional CF2 if necessary):

Accreditation number/Name of Accredited Health Care Professional/Date Signed	Details
Accreditation No.: 1 2 3 4 - 5 6 7 8 9 0 1 - 2 JUANA DELA CRUZ, MD Signature Over Printed Name Date Signed: month - day - year	☑ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____
Accreditation No.: _____ Signature Over Printed Name Date Signed: month - day - year	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____
Accreditation No.: _____ Signature Over Printed Name Date Signed: month - day - year	☐ No co-pay on top of PhilHealth Benefit ☐ With co-pay on top of PhilHealth Benefit P _____

Tick this box if patient paid no additional Professional fee

Tick this box if patient paid an additional Professional fee

PART III - CERTIFICATION OF CONSUMPTION OF BENEFITS AND CONSENT TO ACCESS PATIENT RECORD/S

NOTE: Member/Patient should sign only after the applicable charges have been filled-out

A. CERTIFICATION OF CONSUMPTION OF BENEFITS:

☑ PhilHealth benefit is enough to cover HCI and PF Charges.
No purchase of drugs/medicines, supplies, diagnostics, and co-pay for professional fees by the member/patient.

	Total Actual Charges*
Total Health Care Institution Fees	6,000.00
Total Professional Fees	
Grand Total	6,000.00

Tick this box if patient has NO out of pocket payment

☐ The benefit of the member/patient was completely consumed prior to co-pay OR the benefit of the member/patient is not completely consumed BUT with purchases/expenses for drugs/medicines, supplies, diagnostics and others.

a) The total co-pay for the following are:

	Total Actual Charges*	Amount after Application of Discount (i.e., personal discount, Senior Citizen/PWD)	PhilHealth Benefit	Amount after PhilHealth Deduction
Total Health Care Institution Fees				Amount P _____ Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☐ Others (i.e., PCSO, Promisory note, etc.)
Total Professional Fees (for accredited and/or non-accredited professionals)				Amount P _____ Paid by (check all that applies): ☐ Member/Patient ☐ HMO ☐ Others (i.e., PCSO, Promisory note, etc.)

Tick this box if patient has an out of pocket payment

b) Purchases/Expenses **NOT** included in the Health Care Institution Charges

Total cost of purchase/s for drugs/medicines and/or medical supplies bought by the patient/member within/outside the HCI during confinement	☐ None ☐ Total Amount P _____
Total cost of diagnostic/laboratory examinations paid by the patient/member done within/outside the HCI during confinement	☐ None ☐ Total Amount P _____

* **NOTE:** Total Actual Charges should be based on Statement of Account (SOA)

B. CONSENT TO ACCESS PATIENT RECORD/S:

I hereby consent to the submission and examination of the patient's pertinent medical records for the purpose of verifying the veracity of this claim to effect efficient processing of benefit payment.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all legal liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.

JUAN MASIPAG DELA CRUZ, JR.
Signature Over Printed Name of Member/Patient/Authorized Representative

Affix signature of patient

Date Signed: 0 7 - 2 9 - 2 0 1 9 (month - day - year)

Indicate date signed

If patient/representative is unable to write, put right thumbmark. Patient/Representative should be assisted by an HCI representative.

Relationship of the representative to the member/patient: ☐ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Others, Specify _____

Reason for signing on behalf of the member/patient: ☐ Patient is Incapacitated ☐ Other Reasons _____

☐ Patient ☐ Representative

PART IV - CERTIFICATION OF CONSUMPTION OF HEALTH CARE INSTITUTION

I certify that services rendered were recorded in the patient's chart and health care institution records and that the herein information given are true and correct.

MIGUEL DELOS SANTOS — Signature Over Printed Name of Authorized HCI Representative
RECORDS OFFICER — Official Capacity/Designation
Date Signed: 0 8 - 0 1 - 2 0 1 9 (month - day - year)

Affix signature of HCI representative

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Date: 2/27/19

Checklist of indications for oral secondary prophylaxis

Recommended Dose : (> 27 kg)

Oral Penicillin : 250 mg every 12 hours
Oral Erythromycin : 250 mg every 12 hours; if allergic to penicillin, after meals

Recommended Dose (if < 27 kg):

Oral Erythromycin : 125 mg every 12 hours; if allergic to penicillin, after meals
Oral Penicillin suspension (if available) 125 mg every 12 hours

Who can be shifted to oral prophylaxis?

- ☐ All RF/RHD with moderate to severe mitral stenosis
- ☐ All stage D patients in heart failure who cannot tolerate IM injection
- ☐ All Stage C/D RF/RHD after age 40 years recommended for life time prophylaxis
- ☐ All high risk RF/RHD after surgery- valve replacement surgery/ percutaneous mitral valvuloplasty recommended for lifetime prophylaxis
- ☐ All high risk RF/RHD after surgery- valve repair shifted to oral prophylaxis after age 40
- ☐ With known allergy to penicillin
- ☐ With malnutrition or lean muscle mass to tolerate deep IM penicillin injection

Figure 1: General Process Flow for the Provision of Care for RF/RHD (Step A: Establishing Diagnosis at the OPD/Clinic)

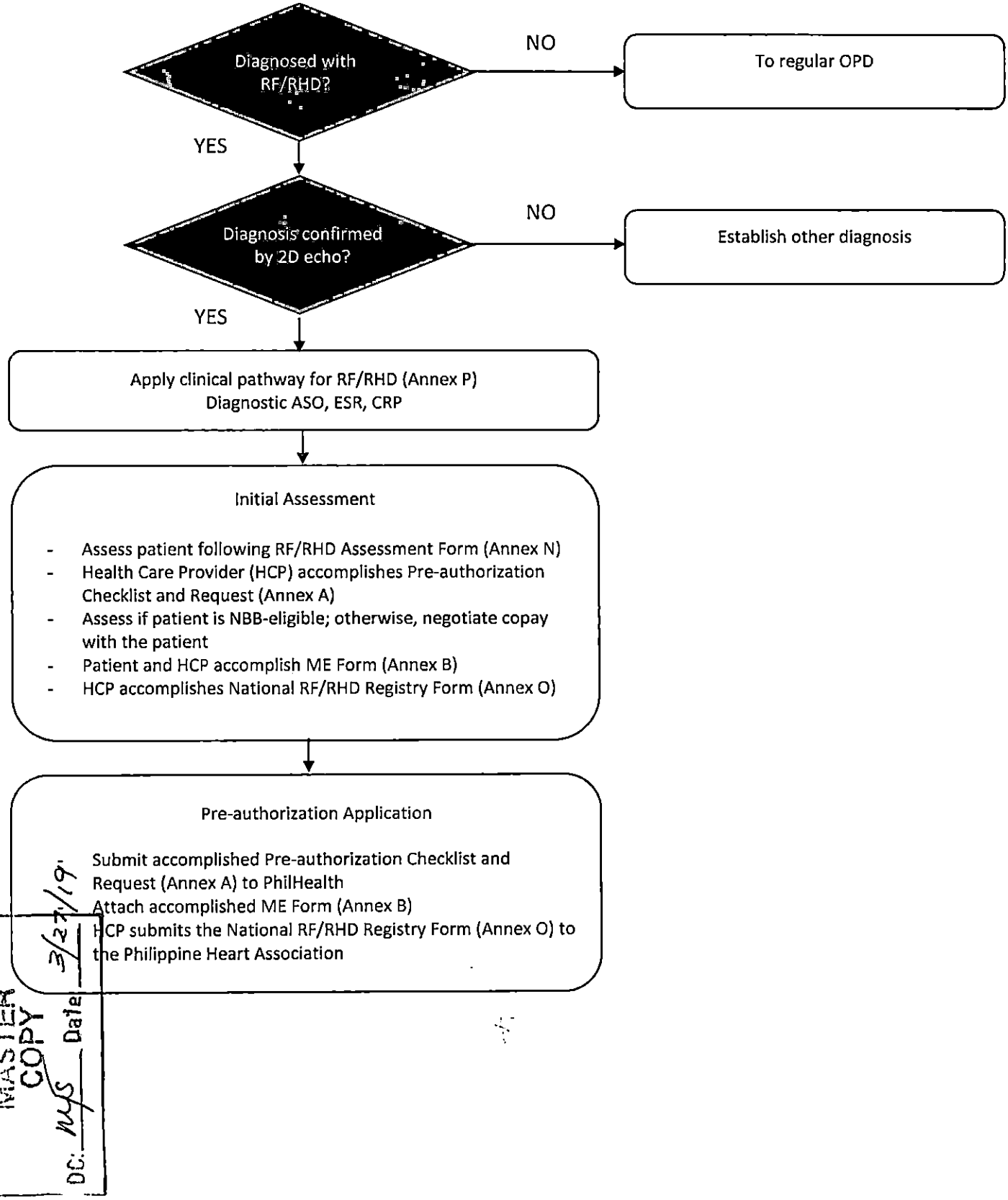
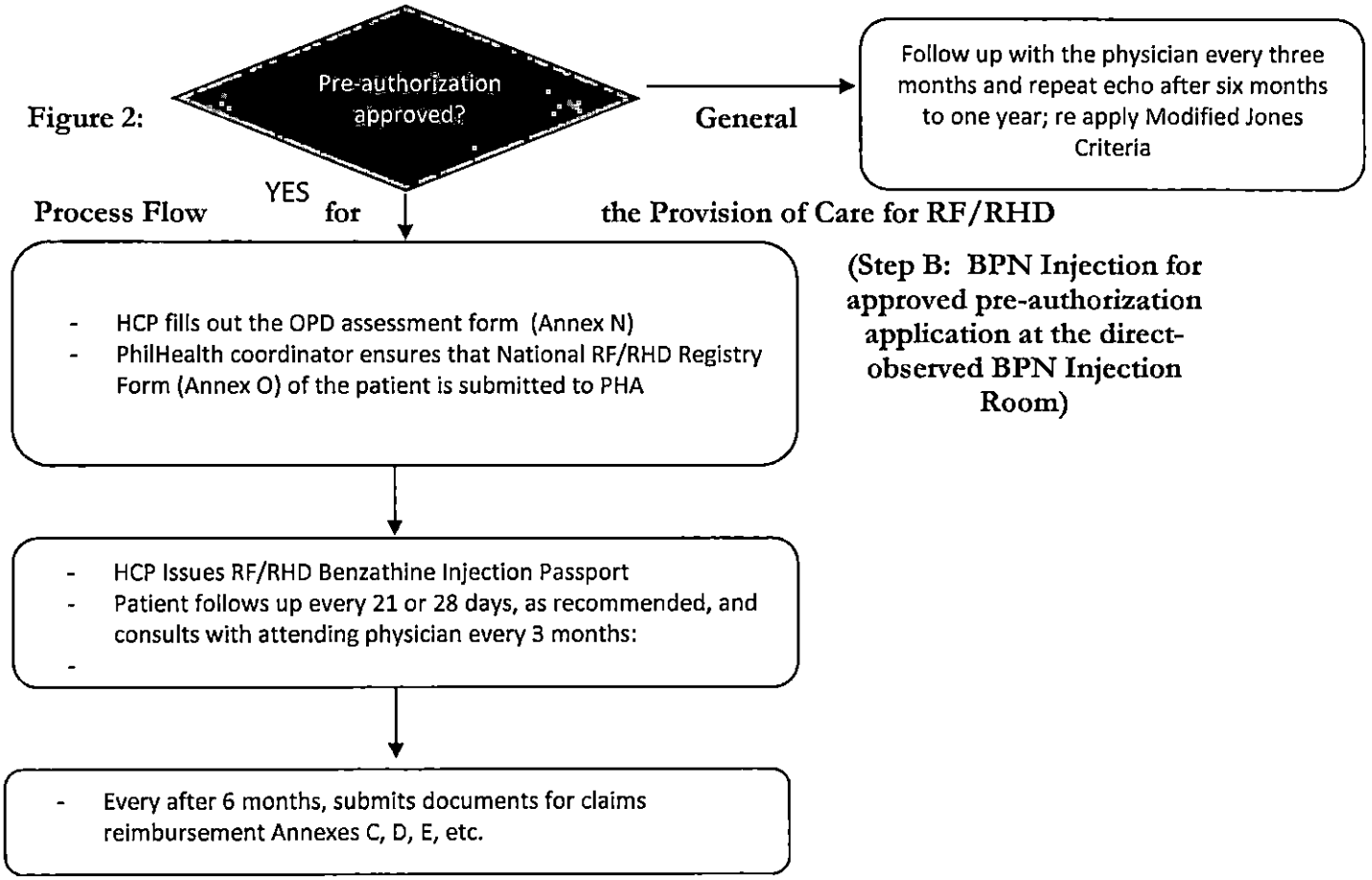


Figure 2: Process Flow for the Provision of Care for RF/RHD



(Step B: BPN Injection for approved pre-authorization application at the direct-observed BPN Injection Room)

Checklist of services that may be outsourced

The following services can be outsourced by Level I hospitals or clinics with RF/RHD Stage A and B patients:

- ☐ OPD diagnostic tests: ASO, ESR, CRP
- ☐ OPD 2D echo
- ☐ Referral to a Cardiologist for confirmation of diagnosis and Clinical Pathway (to a Level II in Stage A and B / Level III hospital in Stage C and D)
- ☐ Referral to a Cardiologist for follow up every 6 months (to a Level 2 in Stage A and B / Level 3 hospital in Stage C and D)

Note: For patients RF/RHD Stage C and D – refer to Level III hospital with specialized cardiac care for tertiary prevention

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Annex "M – RF/RHD"

CHECKLIST FOR PATIENT TRANSFER
Rheumatic Fever/Rheumatic Heart Disease

HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER (answer only if the patient is a dependent)	1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

For RF/RHD patients* who will be transferred to a referral RF/RHD Provider, the following checklist shall be accomplished:

NAME OF REFERRAL RF/RHD CENTER
ADDRESS OF REFERRAL RF/RHD CENTER

Requirements	Yes OR No (tick appropriate box)	Signature of Responsible Person
1. Updated Medical Abstract	☐ Yes ☐ No	
2. Updated Prescription for one (1) month	☐ Yes ☐ No	
3. Letter of Referral from Attending Physician/ Fellow	☐ Yes ☐ No	Name & signature Attending Physician
4. Letter of Intent from Patient requesting for transfer to a referral RF/RHD Provider (Annex G)	☐ Yes ☐ No	Name & signature Patient/Parent/Guardian

Certified complete by: Printed name and signature RF/RHD Coordinator	Conforme by: Printed name and signature Patient/Parent/Guardian
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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Annex "N – RF/RHD"

HOSPITAL LETTERHEAD

RHEUMATIC FEVER/ RHEUMATIC HEART DISEASE

PHILHEALTH OUTPATIENT BENEFIT PACKAGE

SYSTEMATIC CLINICAL ASSESSMENT AND FOLLOW UP FORM

PATIENT'S NAME: _____ LAST NAME FIRST NAME MIDDLE NAME	**DATE OF BIRTH:** _____ **SEX : M ☐ F ☐**	**REGISTRY NO.**
PHILHEALTH PRE-AUTHORIZATION APPROVAL : (Please attach photocopy) **REFERRING HOSPITAL :** _____ _____ **ADDRESS :** _____ **ATTENDING CARDIOLOGIST :** _____	**DATE OF APPROVAL:** _____ **DATE REGISTERED:** _____	**RECOMMENDATION: CATEGORY** **☐ NBB ☐ CO-PAY**
I. ACCOMPLISH RF/RHD SUSPECT PATHWAY : **Chief complaint / Clinical presentation :** _____ **Date of DIAGNOSIS :** _____ ☐ **Rheumatic fever, definite** ☐ **Rheumatic heart disease**	**NURSE ON DUTY : (OPD/ PEDIA CARE)** _____	**SOCIAL SERVICE CONSULTANT** _____

II. ASSESS INVOLVEMENT :

- ☐ 100 Rheumatic Fever without mention of heart involvement ; arthritis, acute or subacute involvement
- ☐ 101.0 Acute rheumatic pericarditis
- ☐ 101.1 Acute rheumatic endocarditis; acute rheumatic valvulitis
- ☐ 101.2 Acute rheumatic myocarditis
- ☐ 101.8 Other acute rheumatic heart disease; acute rheumatic pancarditis
- ☐ 101. 9 Acute rheumatic heart disease unspecified; active rheumatic carditis; acute rheumatic heart disease
- ☐ 102.0 Rheumatic chorea with heat involvement; chorea NOS with heart involvement
- ☐ 102.9 Rheumatic chorea without heart involvement; rheumatic chorea NOS
- ☐ 105.0 Mitral stenosis; rheumatic valve obstruction
- ☐ 105.1 Rheumatic mitral insufficiency; rheumatic mitral regurgitation
- ☐ 105.2 Mitral stenosis with insufficiency; mitral stenosis with insufficiency or incompetence
- ☐ 105.8 Other mitral valve disease; mitral valve failure
- ☐ 105. 9 Mitral valve ds unspecified; chronic mitral valve disorder NOS
- ☐ 106.0 Rheumatic aortic stenosis; aortic valve
- ☐ 106.1 Rheumatic aortic insufficiency; aortic regurgitation
- ☐ 106.2 Rheumatic aortic stenosis with aortic regurgitation
- ☐ 106.8 Other rheumatic aortic valve disease
- ☐ 106.9 Rheumatic aortic valve disease unspecified NOS
- ☐ 107.0 Tricuspid stenosis; Rheumatic valve stenosis
- ☐ 108.0 Disorders of both mitral and aortic valves; whether specified as rheumatic in etiology or NOS
- ☐ 108.1 Disorders of both mitral and tricuspid valves
- ☐ 108.2 Disorders of both aortic and tricuspid valves
- ☐ 108.3 Combined disorders of aortic tricuspid and mitral valves
- ☐ 108.8 Other multiple valve diseases
- ☐ 108.0 Multiple valve disease unspecified
- ☐ 109.0 Rheumatic myocarditis
- ☐ 109.1 Rheumatic diseases of the endocardium; chronic rheumatic valvulitis/ endocarditis
- ☐ 109.2 Chronic rheumatic pericarditis; rheumatic adherent pericardium

III. CHECK IF PROCEDURE/ INTERVENTION DONE	Date of procedure	STATUS
☐ 1 POST MITRAL VALVE REPAIR ☐ 2 POST MITRAL VALVE REPLACEMENT ☐ 3 POST AORTIC VALVE REPLACEMENT ☐ 4 POST MITRAL VALVULOPLASTY ☐ 5 OTHERS		☐ **GOOD** ☐ **REFER TO VALVE TEAM**

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RHEUMATIC FEVER/ RHEUMATIC HEART DISEASE

PHILHEALTH OUTPATIENT BENEFIT PACKAGE
SYSTEMATIC CLINICAL ASSESSMENT AND FOLLOW UP FORM

PATIENT'S NAME: (page 2)	DATE OF BIRTH:	PHILHEALTH ID NO.
_____	_____	
_	SEX : M ☐ F ☐	_____
LAST NAME FIRST NAME MIDDLE NAME		

III. CHECK ANTISTRPTOLYSIN –O (ASO) ☐ NORMAL ☐ INCREASED : START PRIMARY PROPHYLAXIS	DATE	
IV. CHOOSE SECONDARY PROPHYLAXIS : CHECK ALGORITHM RECOMMENDATION (include dose and duration) ☐ IM BPN 1.2 M Units ☐ ORAL ERYTHROMYCIN ☐ ORAL PENICILLIN INTERVAL : ☐ 28 days ☐ 21 days ☐ DAILY (ORAL) ☐ age 18 yrs age 21 yrs old age 40 JUSTIFICATION IF ORAL	DATE :	OTHER REMARKS: RELEVANT HISTORY PHYSICAL EXAM :
V. CHECK FOR DISEASE ACTIVITY : CBC : Hgb ____ Hct _____ WBC : _____ Segmenters _____ ESR _____ CRP _____ Others: MEDICATION	DATE	OTHER REMARKS
VI CHECK HEART FAILURE FUNCTIONAL CLASS : ___ I ___ II ___ III ___ IV Meds : 1 2 3 4	VII. DATE DISCHARGE PLAN : ____ ADMIT ____ OPD FOLLOW UP Date :	

LABORATORY EXAMINATION

2D ECHO FINDINGS YEAR 1 VALVE INVOLVEMENT: LV SIZE : EF : FUNCTIONAL CLASS :	STAGE : (Encircle) A B C D RECOMMENDATION: ☐ SECONDARY PREVENTION ONLY ☐ REFER TO VALVE TEAM IF CLASS C/D INVOLVEMENT	Date ASO ESR CRP Others CBC		
ECHO FINDINGS YEAR 2 VALVE INVOLVEMENT: LV SIZE : EF : FUNCTIONAL CLASS :	STAGE : (Encircle) A B C D RECOMMENDATION: ☐ SECONDARY PREVENTION ONLY ☐ REFER TO VALVE TEAM IF CLASS C / D INVOLVEMENT	Date ASO ESR CRP Others CBC		

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ECHO FINDINGS YEAR 3 VALVE INVOLVEMENT: LV SIZE : EF : FUNCTIONAL CLASS :	STAGE : (Encircle) **A B C D** RECOMMENDATION: ☐ **SECONDARY PREVENTION ONLY** ☐ **REFER TO VALVE TEAM IF CLASS C / D INVOLVEMENT**	Date		
		ASO		
		ESR CRP		
		Others CBC		
ECHO FINDINGS YEAR 4 VALVE INVOLVEMENT: LV SIZE : EF : FUNCTIONAL CLASS :	STAGE : (Encircle) **A B C D** RECOMMENDATION: ☐ **SECONDARY PREVENTION ONLY** ☐ **REFER TO VALVE TEAM IF CLASS C / D INVOLVEMENT**	Date		
		ASO		
		ESR CRP		
		Others CBC		
ECHO FINDINGS YEAR 5 VALVE INVOLVEMENT: LV SIZE : EF : FUNCTIONAL CLASS :	STAGE : (Encircle) **A B C D** RECOMMENDATION: ☐ **SECONDARY PREVENTION ONLY** ☐ **REFER TO VALVE TEAM IF CLASS C / D INVOLVEMENT**	Date		
		ASO		
		ESR CRP		
		Others CBC		

BENZATHINE PENICILLIN COMPLIANCE SUMMARY : % Compliance : Actual Injections x 100 = Total scheduled q 21 days

YEAR	YEAR 1				YEAR 2				YEAR 3			
% Compliance Actual/ Expected												
Signature												
Date	YEAR 4				YEAR 5				**COMPLIANCE RATING**			
% Compliance Actual/ Expected									**E EXCELLEENT 100%** **S SATISFACTORY 90%** **G GOOD >80%** **F FAIR <80%** **P POOR <50%**			
Signature												

VII. IMMUNIZATION HISTORY

Heb B Booster		**PCV Booster (IPD)**	
DPT adult (after 7)		Pneumococcal	
MMR booster		Flu vaccine	
Varicella Booster		Others	
DENTAL CLEARANCE			

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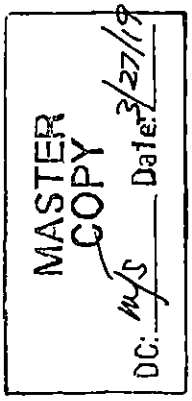
Signature : DATE:_____ TIME :_____	
FOR STAGE C-D : VALVE TEAM RECOMMENDATIONS Signature : DATE:_____ TIME :_____	**OTHER REMARKS:**
FOR STAGE C-D : VALVE TEAM RECOMMENDATIONS REPRESENTATION Signature : DATE:_____ TIME :_____	**OTHER REMARKS :**
SURGERY/ INTERVENTION REFERRAL **Date** _____ **TIME** _____	**Social Service Referral** _____ **STATUS** **Social Service Approval:** _____ **STATUS** **Surgery Pre-op Presentation:** _____ **STATUS** **Tentative Date of Admission** _____ **STATUS**



HOSPITAL LETTERHEAD

Annex "O – RF/RHD"

NATIONAL RF/RHD REGISTRY

DATA SHEET

I. DEMOGRAPHICS

INSTITUTION CODE: _____ **DATE REGISTERED :** _____

PATIENT CODE: _____

REGION (Please encircle):

CAR NCR I
II III IVA
IVB V VI
VII VIII IX
X XI XII
ARMM

YEAR OF BIRTH: _____

SEX:
- ☐ FEMALE
- ☐ MALE

CATEGORY:
- ☐ OPD
- ☐ IN-PATIENT
- ☐ ER
- ☐ PRIVATE CLINIC
- ☐ OTHERS _____

II. DIAGNOSIS

DATE OF DIAGNOSIS: _____

- ☐ Rheumatic Fever
- ☐ Rheumatic Heart Disease

CHECK SYMPTOMS ON INITIAL PRESENTATION

MAJOR
- ☐ Carditis
- ☐ Polyarthritis/ Monoarthritis/ Polyarthralgia
- ☐ Subcutaneous nodules
- ☐ Erythema marginatum
- ☐ Chorea

MINOR
- ☐ Fever
- ☐ Arthralgia
- ☐ ECG: prolonged PR Interval/ 1st degree AV block
- ☐ ESR ___ increased ___ normal
- ☐ CRP ___ increased ___ normal
- ☐ ASO ___ positive ___ normal

IF RHD, CHECK SIGNS/ SYMPTOMS

- ☐ Chest pain
- ☐ Tachycardia
- ☐ Dyspnea
- ☐ Palpitation
- ☐ Hemoptysis
- ☐ Bipedal edema
- ☐ Tachypnea
- ☐ Easy Fatigabilty
- ☐ Syncope
- ☐ Exercise intolerance
- ☐ Nocturnal dyspnea
- ☐ Others

III. ASSESS INVOLVEMENT (encircle the number if applicable):

A. VALVES/ STRUCTURES INVOLVED

- ☐ **100.0** Rheumatic Fever without mention of heart involvement; Arthritis, acute or subacute involvement
- ☐ **101.0** Acute rheumatic pericarditis
- ☐ **101.1** Acute rheumatic endocarditis; acute rheumatic valvulitis
- ☐ **101.2** Acute rheumatic myocarditis
- ☐ **101.8** Other acute rheumatic heart disease; Acute rheumatic pancarditis
- ☐ **101. 9** Acute rheumatic heart disease unspecified; Active rheumatic carditis; Acute rheumatic heart disease
- ☐ **102.0** Rheumatic chorea with heat involvement; chorea NOS with heart involvement
- ☐ **102.9** Rheumatic chorea without heart involvement; Rheumatic chorea NOS
- ☐ **107.0** Tricuspid stenosis; Rheumatic valve stenosis
- ☐ **108.0** Disorders of both mitral and aortic valves; whether specified as rheumatic in etiology or NOS
- ☐ **108.1** Disorders of both mitral and tricuspid valves
- ☐ **108.2** Disorders of both aortic and tricuspid valves
- ☐ **108.3** Combined disorders of aortic, tricuspid and mitral valves

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- ☐ **105.0** Mitral stenosis; Rheumatic valve obstruction
- ☐ **105.1** Rheumatic mitral insufficiency; Rheumatic Mitral regurgitation
- ☐ **105.2** Mitral stenosis with insufficiency; mitral stenosis with insufficiency or incompetence
- ☐ **105.8** Other mitral valve disease; Mitral valve failure
- ☐ **105. 9** Mitral valve ds unspecified; Chronic mitral valve Disorder NOS
- ☐ **106.0** Rheumatic aortic stenosis; aortic valve
- ☐ **106.1** Rheumatic aortic insufficiency; aortic Regurgitation
- ☐ **106.2** Rheumatic aortic stenosis with aortic regurgitation
- ☐ **106.8** Other rheumatic aortic valve disease
- ☐ **106.9** Rheumatic aortic valve disease unspecified NOS
- ☐ **108.0** Multiple valve disease unspecified
- ☐ **108.8** Other multiple valve diseases
- ☐ **109.0** Rheumatic myocarditis
- ☐ **109.1** Rheumatic diseases of the endocardium; Chronic rheumatic Valvulitis/ endocarditis
- ☐ **109.2** Chronic rheumatic pericarditis; Rheumatic adherent pericardium

B. CHECK ECHOCARDIOGRAPHIC CLASSIFICATION BY VALVE INVOLVEMENT (Encircle appropriate Stage)

STAGE	DEFINITION	DESCRIPTION
A	At risk	Patients with risk factors for development of valvular heart disease.
B	Progressive	Patients with progressive VHD (mild- moderate severity and asymptomatic)
C	Asymptomatic severe	Asymptomatic patient who have the criteria for severe VHD C1 : Asymptomatic patients with severe VHD whom the left/right ventricle remains compensated C2 : Asymptomatic patients with severe VHD with decompensation of the left / right ventricle
D	Symptomatic severe	Patients who have developed symptoms as a result of VHD

IV. RECOMMENDATION (based on above Echocardiographic Classification)

☐ STAGE A AND B : SECONDARY PROPHYLAXIS ONLY

☐ STAGE C : SECONDARY AND TERTIARY PROPHYLAXIS
☐ STAGE D : SECONDARY PROPHYLAXIS AND MEDICAL MANAGEMENT OF HEART FAILURE

V. MANAGEMENT

A. SECONDARY PROPHYLAXIS

1. TYPE OF PROPHYLAXIS

☐ **ORAL DAILY**
- o PCN
- o ERYTHROMYCIN
- o OTHERS _____

☐ **IM BPN**
- o every 21 Days *
- o every 28 Days*

2. DURATION

☐ 5 years
☐ Until age 21
☐ Until age 25
☐ Until age 40
☐ For life

COMPLIANCE : (Tick yearly)

	POOR	FAIR	GOOD	EXCELLENT
Year 1				
Year 2				
Year 3				
Year 4				
Year 5				
Year 6				
Year 7				
Year 8				
Year 9				
Year 10				

Compliance for IM BPN/ year

	Every 21 days	Every 28 days
POOR (< 50%)	< 12	< 7
FAIR (50 – 80%)	13 – 14	8 – 10
GOOD (> 80%)	15 -16	11 – 12
EXCELLENT (100%)	17	13

IF COMPLIANCE IS FAIR CHECK REASON/S:

☐ DIFFICULTY TO TRAVEL TO HEALTH CARE INSTITUTION
☐ DRUG NOT AVAILABLE
☐ OTHERS _____

B. TERTIARY PROPHYLAXIS:

CHECK RECOMMENDATION (by the VALVE TEAM)

☐ VALVE REPLACEMENT
- o Mitral Valve Replacement
- o Aortic Valve Replacement
- o Mitral and Aortic Valve Replacement

☐ VALVE REPAIR (Specify valve _____)
☐ Percutaneous Mitral Balloon Valvotomy

DATE PRESENTED TO VALVE TEAM: _____
VALVE TEAM REPRESENTATIVE (Print Name)
_____

C. IF PROCEDURE/ INTERVENTION DONE TICK/ CHECK :

☐ POST MITRAL VALVE REPAIR
☐ POST MITRAL VALVE REPLACEMENT
☐ POST AORTIC VALVE REPAIR
☐ POST AORTIC VALVE REPLACEMENT
☐ POST MITRAL VALVULOPLASTY
☐ POST TRICUSPID VALVE REPAIR
☐ OTHERS _____

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TENTATIVE SCHEDULE :

DATE OF PROCEDURE:

STATUS AFTER SURGERY:

☐ **CLEARED In NEXT 5 YRS**
☐ **RE EVALUATE YEARLY (If with residual lesion)**
☐ **RE-OPERATION NEEDED** _____

ATTENDING CARDIOLOGIST / RFRHD Coordinator (Print name)

Physician -on duty (Print name)

CLINICAL PATHWAY
THE RHEUMATIC FEVER SUSPECT

HOSPITAL NAME
DEPARTMENT OF _____
CLINICAL PATHWAY -THE RHEUMATIC FEVER SUSPECT
(SYSTEMATIC CLINICAL AND MANAGEMENT PATHWAY)

INCLUSION CRITERIA:

- Age 3 -25 years of age
- Chief complaint of any of the following:
  a) Recurrent Strep throat infection
  b) Joint pain/swelling with or without fever of ≤ 2 weeks
  c) New unexplained murmur
  d) Heart failure: fast heart rate ± tachypnea
  e) Motor instability/movement disorder

EXCLUSION CRITERIA:

- Presence of any focus of infection by Chest x-ray and/or urinalysis
- Proven diagnosis of other immunologic disease, ie. SLE, Rheumatoid Arthritis of any type

PATIENT'S NAME:	BIRTHDATE	HOSPITAL NUMBER
_____	_____	_____
LAST NAME FIRST NAME MIDDLE NAME	M____ F____	

DAY 1: Pathway Activated: Date: _____ **Time:**_____ **OPD** ☐ **EMERGENCY ROOM** ☐ **IN-PATIENT** ☐

PHYSICIAN'S NOTES	PHYSICIAN'S ORDERS	VARIANCE	SIGN
Check subjective CHIEF complaints/symptoms: _____ _____ **Vital signs:** BP: HR: RR: Temp: Ht: Wt: BSA: BMI: O2 sat: Latest Clinical Findings: Skin: __pale __pink __jaundice __cyanotic Pupils (size/reactivity): _____ Conjunctivae (pink / pale) Chest expansion: _____ Lung (breath sounds): _____ Heart (murmurs): _____ Abdomen: Liver edge:_____ Peripheral and Central pulses:_____ Extremities: Warm / cold CRT: ___ <2sec ___> 2 sec Neuro exam: _____	**I.** APPLY JONES CRITERIA AS FOLLOWS: A. Check / qualify symptoms at least any one of the following **MAJOR MANIFESTATIONS** 1. IF with JOINT PAINS , CHECK IF at least **ANY TWO** of the following is true: ☐ Migratory in nature ☐ Large joints, asymmetrical ☐ With tenderness , arthralgia ☐ Pain on locomotion ☐ Instantaneous relief with antipyretic/ anti-inflammatory drugs ☐ No joint deformity 2. IF with CARDITIS , check if **ANY ONE** of the following is present: ☐ Chest pain ☐ Tachypnea for age ☐ Tachycardia for age ☐ Sleeping HR >100/min ☐ Pallor at rest or with activity ☐ Functional Classification: _____ ☐ PE: with murmur : _____ _____ _____ 3. IF with ERYTHYMATOUS, NON-PRURITIC RASH , Check if **ANY ONE** of the following is true: ☐ Transient, serpiginous with irregular margins and pale center ☐ More on trunks and limbs ☐ Worsens with application of heat and disappears ☐ With cold exposure ☐ Unaffected by anti-inflammatory drugs	A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__	

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HOSPITAL NAME
DEPARTMENT OF _____

CLINICAL PATHWAY -THE RHEUMATIC FEVER SUSPECT
(SYSTEMATIC CLINICAL AND MANAGEMENT PATHWAY)

PATIENT'S NAME:			**BIRTHDATE**	**HOSPITAL NUMBER**
LAST NAME	**FIRST NAME**	**MIDDLE NAME**	**M____ F____**	_____

DAY 1 : Date: _____ (page 2)

PHYSICIAN'S NOTES	PHYSICIAN'S ORDERS	VARIANCE	SIGN
NURSING ASSESSMENT: Braden Risk Score: _____ General Pain Assessment: _____ NIPS – FACES: _____ Fall Risk Score: _____	4. IF with unusual movement disorder / CHOREA; Check if **ANY ONE** of the following is present : ☐ Initial clumsiness, emotional lability,or grimacing of face ☐ "St Vitus dance" during movement ☐ Disappears at rest or during sleep ☐ Check for handwriting irregularity with strokes ☐ Stretch out both hands and check if one hand falls versus the other hand 5. IF with PEA SIZED SUBCUTANEOUS NODULES, check if **ANY ONE** of the following is true: ☐ Hard and painless ☐ Occur over extensor surfaces of joints, spine, scapulae and scalp ☐ Lasts for weeks B. Check for any one of the following as **MINOR MANIFESTATION/S**: ☐ Unexplained fever at least 3 -5 days ☐ Arthralgia , recurrent ☐ Pallor ☐ Loss of weight **II.** Request for the following Laboratory: • CBC with platelet • Anti-Streptolysin O (ASO) titer • ESR, CRP • ECG • 2DEcho with CFDS ☐ Chest X-ray (PA-L) ☐ Anti-DNase, if available ☐ Rheumatoid factor, if available **III.** DIAGNOSE AS **RHEUMATIC FEVER** IF ANY of the following is true and proceed with pathway (Section V): ☐ Any TWO (2) Major Manifestations in IA (1-5) ☐ Any One (1) Major Manifestation in IA (1-5) PLUS any two (2) minor criteria in IB and II ☐ Diagnosed case of RHD plus 2 Major OR 1 Major plus 2 Minor OR 3 Minor	A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__	

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HOSPITAL NAME
DEPARTMENT OF _____
CLINICAL PATHWAY -THE RHEUMATIC FEVER SUSPECT
(SYSTEMATIC CLINICAL AND MANAGEMENT PATHWAY)

PATIENT'S NAME: _____ LAST NAME FIRST NAME MIDDLE NAME	BIRTHDATE _____ M____ F____	HOSPITAL NUMBER _____

DAY 1 : Date: _____ (page 3)

PHYSICIAN'S NOTES	PHYSICIAN'S ORDERS	VARIANCE	SIGN
	IV. DIAGNOSE AS <u>RHEUMATIC FEVER SUSPECT</u> If ANY of the following is true (Proceed to discharge planning) ☐ Symptoms/ clinical presentations do not completely fulfill criteria as Major Manifestation ☐ Only minor manifestations are present V. MEDICATIONS (if needed) 1. GIVE PRIMARY PROPHYLAXIS (For ASO +) ☐ Single dose deep IM Benzathine Penicillin ☐ Oral PCN VK 50 mg/kg/day for 10 days: Dose: _____ ☐ Erythromycin if allergic to PCN 50 mkd for 10 days: _____ _____ 2. Give anti-inflammatory If ACTIVE for 4 weeks: ☐ ASA 60-70 mg/kg/d max 3gms/day After meals IF ARTHRITIS is major symptom: Dose: _____ _____ ☐ Prednisone 1-2 mg/kg/day for 4 weeks then Taper in 2 weeks: Dose: _____ _____ 3. Treat CONGESTIVE HEART FAILURE if present ☐ Digoxin : _____ _____ ☐ Furosemide : _____ _____ ☐ Vasodilator (Captopril) _____ _____ ☐ Others: _____ _____ VI. Check if consults with following services are needed (indicate name of specialist): ☐ Nephrology _____ ☐ Neurology _____ ☐ Hematology _____ ☐ Infectious _____ ☐ Rheumatology _____ ☐ Others _____	A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__	

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HOSPITAL NAME
DEPARTMENT OF _____

CLINICAL PATHWAY -THE RHEUMATIC FEVER SUSPECT
(SYSTEMATIC CLINICAL AND MANAGEMENT PATHWAY)

PATIENT'S NAME: _____ LAST NAME FIRST NAME MIDDLE NAME	BIRTHDATE _____ M____ F____	HOSPITAL NUMBER _____

DAY 1 : Date: _____ (page 3)

PHYSICIAN'S NOTES	PHYSICIAN'S ORDERS	VARIANCE	SIGN
	VII. Diet/Nutrition:_____	A__ B__ C__ D__	
	VIII. Safety (see Nursing and Safety Protocol)	A__ B__ C__ D__	
	IX. Provide Psychosocial/Spiritual support to: ☐ Therapy appropriate for age ☐ Inquire about the need for psychological evaluation (CHEERS protocol)	A__ B__ C__ D__ A__ B__ C__ D__	
	X. Patient/Family Education: ☐ Disease process, course of disease ☐ Explain pathophysiology as non-infectious ☐ Discuss Clinical Pathway with Family	A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__	
	XI. PARENTS/GUARDIAN UNDERSTOOD, VERBALIZED, CONSENTED AND SIGNED THE RF CARE PLAN ☐ Yes ☐ No	A__ B__ C__ D__ A__ B__ C__ D__	
	XII. OUTCOME GOALS: ☐ Vital signs stable ☐ Admit if in heart failure Or unable to ambulate or Fever more than 7days ☐ Pathway and procedures clear to parents/guardian	A__ B__ C__ D__ A__ B__ C__ D__ A__ B__ C__ D__	
	XIII. DISCHARGE PLANNING: ☐ Estimated date of follow up with results: _____ ☐ Observe for recurrence of Major and Minor Criteria and follow-up immediately ☐ Discharged from OPD, terminate pathway and refer to General Pediatrician	A__ B__ C__ D__ A__ B__ C__ D__	

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ACTIVATED BY:	ACKNOWLEDGED BY:	
_____ ATTENDING PHYSICIAN/FELLOW-ON-DUTY Signature over Printed Name Date/Time _____	_____ NURSE-IN-CHARGE (AM SHIFT) Signature over Printed Name Date/Time _____	_____ NURSE-IN-CHARGE (PM SHIFT) Signature over Printed Name Date/Time _____