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

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

	MANDATORY SERVICES	Status	OTHER SERVICES, as needed	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: _____		Indicate date/s done or NA if not applicable
C. Laboratory exam			☐ ASO	
			☐ ESR	
			☐ CRP	
			☐ CBC with platelet	
			☐ EKG	
			☐ Chest X-ray	
D. Others			aspirin	
			prednisone	
			antacid	
E.	Date of initial registration in the RF/RHD Registry	Date		

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)