Annex "N – RF/RHD"

HOSPITAL LETTERHEAD

RHEUMATIC FEVER/ RHEUMATIC HEART DISEASE

PHILHEALTH OUTPATIENT BENEFIT PACKAGE

SYSTEMATIC CLINICAL ASSESSMENT AND FOLLOW UP FORM

<table>
<tr><td colspan="2">PATIENT'S NAME:
_____
LAST NAME FIRST NAME MIDDLE NAME</td><td>DATE OF BIRTH:
_____
SEX : M ☐ F ☐</td><td>REGISTRY NO.</td></tr>
<tr><td colspan="2">PHILHEALTH PRE-AUTHORIZATION APPROVAL : (Please attach photocopy)
REFERRING HOSPITAL : _____
_____
ADDRESS :
_____
ATTENDING CARDIOLOGIST :
_____</td><td>DATE OF APPROVAL:
_____
DATE REGISTERED:
_____</td><td>RECOMMENDATION: CATEGORY
☐ NBB ☐ CO-PAY</td></tr>
<tr><td colspan="2">I. ACCOMPLISH RF/RHD SUSPECT PATHWAY :
Chief complaint / Clinical presentation : _____
Date of DIAGNOSIS : _____
☐ Rheumatic fever, definite
☐ Rheumatic heart disease</td><td>NURSE ON DUTY : (OPD/ PEDIA CARE)
_____</td><td>SOCIAL SERVICE CONSULTANT
_____</td></tr>
<tr><td colspan="2">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</td><td colspan="2">☐ 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</td></tr>
<tr><td colspan="2">☐ 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</td><td colspan="2">☐ 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</td></tr>
<tr><td colspan="2">III. CHECK IF PROCEDURE/ INTERVENTION DONE
☐ 1 POST MITRAL VALVE REPAIR
☐ 2 POST MITRAL VALVE REPLACEMENT
☐ 3 POST AORTIC VALVE REPLACEMENT
☐ 4 POST MITRAL VALVULOPLASTY
☐ 5 OTHERS</td><td>Date of procedure</td><td>STATUS
☐ GOOD
☐ REFER TO VALVE TEAM</td></tr>
</table>

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

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

	CLASS C / D INVOLVEMENT	Others CBC		
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 Actual/ Expected								
Signature								

COMPLIANCE RATING

E	**EXCELLEENT**	**100%**
S	**SATISFACTORY**	**90%**
G	**GOOD**	**>80%**
F	**FAIR**	**<80%**
P	**POOR**	**<50%**

VII. IMMUNIZATION HISTORY

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

DENTAL CLEARANCE 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**