Annex B.1: Checklist of Mandatory and Other Services (0 to less than 6 Months Old - Tranche 1

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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PhilHealthOfficial teamphilhealth

Case No. _______________

Place a (√) in the appropriate tick box

MANDATORY AND OTHER SERVICES	
Initial Assessment for SAM (anthropometric and clinical)	
☐ Assessment	Date (mm/dd/yyyy): ____________
Counseling ☐ IYCF Counseling and support for exclusive breastfeeding	Date (mm/dd/yyyy): ____________
☐ Nutritional Counseling	Date (mm/dd/yyyy): ____________
☐ Water, Sanitation, and Hygiene (WASH)	Date (mm/dd/yyyy): ____________
☐ Child development and nurturing care	Date (mm/dd/yyyy): ____________
Other Services ☐ Referral Outpatient Therapeutic Care (OTC) to Inpatient Therapeutic Care (ITC)[a]	Date (mm/dd/yyyy): ____________
☐ Medical complications, maternal health, mental and social well-being check	Date (mm/dd/yyyy): ____________

[a] Required when a child fails the appetite test, worsening edema or development of a medical complications based on the PIMAM guidelines, or in case of failure to respond treatment

HEALTH FACILITY (HF)		
ADDRESS OF HF		
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; otherwise, write, "same as above")** 1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

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