

Annex B.3: Checklist of Mandatory and Other Services (6 to 60 Months Old) - Tranche 1



Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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 PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH FACILITY (HF)					
ADDRESS OF HF					
A. PATIENT	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; padding: 5px;">1. Last Name, First Name, Middle Name, Suffix</td> <td style="width: 30%; padding: 5px;">SEX <input type="checkbox"/> Male <input type="checkbox"/> Female</td> </tr> <tr> <td colspan="2" style="padding: 5px;">2. PhilHealth ID Number □□ - □□□□□□□□□□ - □</td> </tr> </table>	1. Last Name, First Name, Middle Name, Suffix	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	2. PhilHealth ID Number □□ - □□□□□□□□□□ - □	
1. Last Name, First Name, Middle Name, Suffix	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female				
2. PhilHealth ID Number □□ - □□□□□□□□□□ - □					
B. MEMBER	<p>(Answer only if the patient is a dependent; otherwise, write, "same as above")</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; padding: 5px;">1. Last Name, First Name, Middle Name, Suffix</td> </tr> <tr> <td style="padding: 5px;">2. PhilHealth ID Number □□ - □□□□□□□□□□ - □</td> </tr> </table>	1. Last Name, First Name, Middle Name, Suffix	2. PhilHealth ID Number □□ - □□□□□□□□□□ - □		
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2. PhilHealth ID Number □□ - □□□□□□□□□□ - □					
MANDATORY AND OTHER SERVICES					
Initial Assessment for SAM (anthropometric and clinical)					
<input type="checkbox"/> Assessment	Date (mm/dd/yyyy): _____				
Counseling <input type="checkbox"/> Infant and young child feeding counseling and support: Breastfeeding (up to 2 years or beyond) and appropriate complementary feeding, counsel on meal frequency and food diversity	Date (mm/dd/yyyy): _____				
<input type="checkbox"/> Nutritional Counseling	Date (mm/dd/yyyy): _____				
<input type="checkbox"/> Water, Sanitation, and Hygiene (WASH)	Date (mm/dd/yyyy): _____				
<input type="checkbox"/> Commodities (RUTF) ^a	Date (mm/dd/yyyy): _____				
OTHER SERVICES					
<input type="checkbox"/> Medicines and Medical Supplies ^b	Date (mm/dd/yyyy): _____				
<input type="checkbox"/> Referral Outpatient Therapeutic Care (OTC) to Inpatient Therapeutic Care (ITC) ^c	Date (mm/dd/yyyy): _____				
<input type="checkbox"/> Medical complications, maternal health, mental and social well-being check	Date (mm/dd/yyyy): _____				

^a Ready to Use Supplementary Food (RUSF) as an alternative to RUTF under exceptional circumstances in accordance with DOH standards

^b Required to be given to SAM patient if prescribed by the physician

^c 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

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