

## Annex F: Post-Kidney Transplant Passport



Republic of the Philippines  
**PHILIPPINE HEALTH INSURANCE CORPORATION**  
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 PhilHealthOfficial teamphilhealth

**Case No.** \_\_\_\_\_

HEALTH FACILITY (HF)		
ADDRESS OF HF		AGE: _____
<b>A. PATIENT</b>	1. Last Name, First Name, Suffix, Middle Name	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
	2. PhilHealth ID Number <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>	
<b>B. MEMBER</b>	<b>(Answer only if the patient is a dependent; otherwise, write, "same as above")</b>	
	1. Last Name, First Name, Middle Name, Suffix	
2. PhilHealth ID Number <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>		

### Post Kidney Transplant Passport

Calendar Year: \_\_\_\_\_

#### A. Immunosuppressive medicines

Name of Drug		Dosage	Preparation	Date Dispensed (mm/dd/yyyy)	Quantity	Patient/Parent/Guardian's Signature	Attending Physician's signature
Generic Name	Brand Name						
1.							
2.							
3.							
4.							
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18.							



Name of Drug		Dosage	Preparation	Date Dispensed (mm/dd/yyyy)	Quantity	Patient/ Parent/ Guardian's Signature	Attending Physician's signature
Generic Name	Brand Name						
19.							
20.							
21.							
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**B. Drug Prophylaxis**

Name of Drug		Dosage	Preparation	Date Dispensed (mm/dd/yyyy)	Quantity	Patient/ Parent/ Guardian's Signature	Attending Physician's signature
Generic Name	Brand Name						
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							

Name of Drug		Dosage	Preparation	Date Dispensed (mm/dd/yyyy)	Quantity	Patient/ Parent/ Guardian's Signature	Attending Physician's signature
Generic Name	Brand Name						
13.							
14.							
15.							
16.							
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**C. Drug Level Monitoring**

Description	Date Given (mm/dd/yyyy)	Patient/ Parent/ Guardian's Signature	Attending Physician's signature
1.			
2.			
3.			
4.			
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6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
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17.			

Description	Date Given (mm/dd/yyyy)	Patient/ Parent/ Guardian's Signature	Attending Physician's signature
18.			
19.			
20.			
21.			
22.			
23.			
24.			

**D. Laboratory Tests**

Description	Date Given (mm/dd/yyyy)	Patient/ Parent/ Guardian's Signature	Attending Physician's signature
1.			
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29.			

Description	Date Given (mm/dd/yyyy)	Patient/ Parent/ Guardian's Signature	Attending Physician's signature
30.			
31.			
32.			
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**E. Renal Graft Biopsy**

Description	Date Given (mm/dd/yyyy)	Patient/ Parent/ Guardian's Signature	Attending Physician's signature

**F. Diagnostic Tests**

Description	Date Given (mm/dd/yyyy)	Patient/ Parent/ Guardian's Signature	Attending Physician's signature
1.			
2.			
3.			

**G. Infectious Disease Monitoring**

Description	Date Given (mm/dd/yyyy)	Patient/ Parent/ Guardian's Signature	Attending Physician's signature
1.			
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11.			
12.			

Description	Date Given (mm/dd/yyyy)	Patient/ Parent/ Guardian's Signature	Attending Physician's signature
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19.			
20.			
21.			
22.			
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24.			

H. Ancillary Services

Description	Date Given (mm/dd/yyyy)	Patient/ Parent/ Guardian's Signature	Attending Physician's signature
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