Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

PhilHealth Your Partner in Health
BAGONG PILIPINAS

Case No. ________________

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	☐ Same as patient (Answer the following only if the patient is a dependent) 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

Checklist of Essential Health Services - Kidney Transplant Recipient - Adult

Place a (✔) in the appropriate tick box if the service is done or given.

Immunosuppressive Medications*			
Description	Date dispensed (mm/dd/yyyy)		
Calcineurin inhibitor (CNI): ☐ Tacrolimus ☐ Cyclosporine (ciclosporin)			
Anti-proliferative: ☐ Mycophenolic acid (mycophenolate sodium or mycophenolate mofetil) ☐ Azathioprine			
mTOR: ☐ Everolimus ☐ Sirolimus			
Corticoteroids: ☐ Prednisone ☐ Prednisolone			

*Any of the following immunosuppression combinations:
1. Calcineurin inhibitors (CNI) + Anti-Proliferative +/- Corticosteroid; OR
2. CNI + mTOR inhibitor +/- Corticosteroid; OR
3. mTOR inhibitors + Anti-Proliferative +/- Corticosteroid.

SOCOTEC ISO 9001
PAB ACCREDITED QMS CERTIFICATION BODY

Drug Prophylaxis	
Description	Date dispensed (mm/dd/yyyy)
☐ Nystatin	
☐ Valacyclovir OR ☐ Valganciclovir	
☐ Isoniazid (INH)	
☐ Cotrimoxazole	

Drug Level Monitoring*	
Description	Date (mm/dd/yyyy)
☐ Tacrolimus (trough) ☐ Cyclosporine (trough or C2) ☐ Sirolimus (trough) ☐ Everolimus (trough)	1. ____ 2. ____ 3. ____ 4. ____ 5. ____ 6. ____ 7. ____ 8. ____ 9. ____ 10. ____
*The following rules shall apply: 1. Maximum availment of 10x ; Applicable to kidney recipients during the first year after the kidney transplant procedure; 2. Maximum availment of 4x a year; Applicable to kidney recipients starting from the 13th month after the kidney transplant procedure	

Laboratory Tests*						
Description	Date (mm/dd/yyyy)					
As prescribed:						
☐ Complete blood count (CBC)						
☐ Creatinine						
☐ Sodium (Na)						
☐ Potassium (K)						
☐ Fasting blood sugar (FBS)						
☐ Serum glutamic pyruvic transaminase (SGPT)						
☐ Urinalysis						
☐ Urine total protein creatinine ratio (UTPCR) or Urine albumin creatinine ratio (UACR)						

Laboratory Tests*						
Description	Date (mm/dd/yyyy)					
Lipid profile: □ Total cholesterol □ High-density lipoprotein (HDL) cholesterol □ Low-density lipoprotein (LDL) cholesterol □ Triglycerides						
As indicated:						
□ Albumin						
□ Prothrombin time (PT)						
□ Partial thromboplastin time (PTT)						
□ HbA1c						
*Laboratory tests can be prescribed multiple times, subject to the amount limit per claim						

Procedure	
Description	Date (mm/dd/yyyy)
□ Renal graft biopsy (Once a year, if indicated)	

Diagnostic Tests	
Description	Date (mm/dd/yyyy)
□ Chest X-ray*	
□ Whole abdominal ultrasound*	
□ Renal graft doppler (as indicated)*	
*Once a year	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Nephrologist/Transplant Surgeon	(Printed name and signature) Patient/Parent/Legal Guardian
PhilHealth Accreditation No. ______________________________ Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)