

## Annex E.2.: Checklist of Essential Health Services - Living Kidney Donor



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

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

HEALTH FACILITY (HF)		
ADDRESS OF HF		
<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"/>
<b>B. MEMBER</b>	<input type="checkbox"/> 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	<input type="text"/> - <input type="text"/> - <input type="text"/>

### Checklist of Essential Health Services -Living Kidney Donor

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

Essential Health Services	
Mandatory Services	As needed / As indicated
<input type="checkbox"/> <b>Creatinine</b> Date(mm/dd/yyyy) 1. _____ 2. _____ 3. _____ 4. _____	<input type="checkbox"/> <b>Fasting blood sugar (FBS)</b> Date(mm/dd/yyyy) 1. _____ 2. _____
<input type="checkbox"/> <b>Urinalysis</b> Date(mm/dd/yyyy) 1. _____ 2. _____ 3. _____ 4. _____	<input type="checkbox"/> <b>Random urine total protein:creatinine ratio</b> or <input type="checkbox"/> <b>random urine albumin:creatinine ratio</b> Date(mm/dd/yyyy) 1. _____ 2. _____

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

