Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "C1 – ALL"

CHECKLIST OF MANDATORY AND OTHER SERVICES
Acute Lymphocytic/Lymphoblastic Leukemia (Standard Risk)
Induction Phase

Tranche 1

HEALTH CARE *PROVIDER (HCP)*		
ADDRESS OF *HCP*		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	*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, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
DATE OF END OF INDUCTION PHASE (mm/dd/yyyy)		

Place a (✓) in the appropriate tick box if *the service is* given

MANDATORY SERVICES	OTHER SERVICES (As needed/ as indicated)
A. **Diagnostics**	
☐ Bone marrow aspirate examination (morphologic assessment of BMA smears)	
☐ CSF analysis with WBC differential count	
☐ CBC (with platelet count)	
☐ Alanine aminotransferase (ALT)	
☐ Bilirubin	
☐ Creatinine	
☐ PT/PTT	
Electrolytes	
☐ Sodium	☐ Calcium
☐ Potassium	☐ Chloride
	☐ Magnesium
	☐ Phosphorous/*Phosphate*

Place a (✓) in the appropriate tick box if *the service is* given

MANDATORY SERVICES	OTHER SERVICES (As needed/ as indicated)
☐ Uric acid	☐ 2D echocardiography
☐ Chest X-ray	☐ Flow cytometric immunophenotyping
	☐ CSF cytospin
	☐ Abdominal ultrasound
	☐ Evaluation of infection (ex. blood culture)
	☐ Others, indicate (ex. cytogenetics)
	Blood support and processing:
	☐ Blood typing
	☐ Cross matching
	☐ Blood screening
	☐ Blood products (packed RBC/platelet concentrate/ fresh frozen plasma)
Complete list of medicines given	
Chemotherapy:	
☐ Systemic	
☐ prednisone *or dexamethasone* ☐ vincristine	
☐ L-asparaginase	☐ doxorubicin
☐ Intrathecal	
☐ Single (methotrexate) OR	
☐ Triple (methotrexate, cytarabine, hydrocortisone)	
	Other drugs:
	☐ diphenhydramine
	☐ hydrocortisone
	Anti-emetics:
	☐ ondansetron
	☐ metoclopramide
	Pain medications:
	☐ nalbuphine
	☐ tramadol

Place a (✓) in the appropriate tick box if *the service is* given

MANDATORY SERVICES	OTHER SERVICES (As needed/ as indicated)
	Anesthetics:
	☐ ketamine
	☐ propofol
	Sedatives (prior to procedure):
	☐ midazolam
	☐ diphenhydramine
	Antimicrobials:
	☐ cotrimoxazole
	☐ ceftriaxone
	☐ ceftazidime
	☐ amikacin
	☐ antifungal (oral) specify,
	☐ other *antimicrobials* based on hospital antibiogram specify,

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