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

Case No. _____

Annex "C3 – ALL"

CHECKLIST OF MANDATORY AND OTHER SERVICES
Acute Lymphocytic/Lymphoblastic Leukemia (Standard Risk)
After *6th* Maintenance Cycle

Tranche 3

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 6th MAINTENANCE CYCLE (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**	
☐ CSF Analysis WBC differential count	☐ Chest X-ray
☐ CBC with platelet count	☐ Bone marrow aspirate examination
	☐ Alanine aminotransferase (ALT)
	☐ Creatinine
	☐ Bilirubin
	☐ Amylase
	☐ Cranial CT scan
	☐ CSF cytospin
	☐ Minimal residual disease by flow cytometry

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

MANDATORY SERVICES	**OTHER SERVICES (As needed/ as indicated)**
Complete list of medicines given	
Chemotherapy	
☐ Systemic	
☐ prednisone *or dexamethasone*	☐ doxorubicin
☐ vincristine	
☐ methotrexate (oral)	
☐ 6-mercaptopurine	
☐ Intrathecal	
☐ Single (methotrexate) OR	
☐ Triple (methotrexate, cytarabine, hydrocortisone)	
	Anti-emetics
	☐ ondansetron
	☐ metoclopramide
	Antimicrobials
	☐ cotrimoxazole
	☐ ceftriaxone
	☐ ceftazidime
	☐ amikacin
	☐ *antifungal (oral), specify*
	☐ Other antibiotics based on hospital antibiogram Specify: _____ _____
	☐ Blood products

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)	