Case No. _____

Annex "C1 – ALL"

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

Tranche 1

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

Place a (✓) in the status column if DONE or NA if not applicable.

MANDATORY AND OTHER SERVICES	Status
A. Diagnostics	
1. Bone marrow aspirate examination (morphologic assessment of BMA smears)	
2. CSF analysis with WBC differential count	
3. CBC (with platelet count)	
4. Alanine aminotransferase (ALT)	
5. Bilirubin	
6. Creatinine	
7. PT/PTT	
8. Electrolytes	
a. Sodium	
b. Potassium	
c. Calcium	
d. Chloride	
e. Magnesium, as needed	
f. Phosphorous, as needed	

Place a (✓) in the status column if DONE or NA if not applicable.

MANDATORY AND OTHER SERVICES	Status
9. Uric acid	
10. Chest X-ray	
11. 2D echocardiography, as needed	
12. Flow cytometric immunophenotyping, as needed	
13. CSF cytospin, as needed	
14. Abdominal ultrasound, as needed	
15. Evaluation of infection (ex. blood culture), as needed	
16. Others, indicate (ex. cytogenetics), as needed	
B. Blood support and processing, as needed	
1. Blood typing	
2. Cross matching	
3. Blood screening	
4. Blood products (packed RBC/platelet concentrate/fresh frozen plasma)	
C. Complete list of medicines given	
1. Chemotherapy	
a. Systemic	
i. vincristine	
ii. L-asparaginase	
iii. doxorubicin (as indicated)	
b. Intrathecal	
i. Single (methotrexate) OR	
ii. Triple (methotrexate, cytarabine, hydrocortisone)	
2. Other drugs (as indicated)	
a. prednisone	
b. diphenhydramine	
c. hydrocortisone	
3. Anti-emetics (as indicated)	
a. ondansetron	
b. metoclopramide	
4. Pain medications (as indicated)	
a. nalbuphine	
b. tramadol	

Place a (✓) in the status column if DONE or NA if not applicable.

MANDATORY AND OTHER SERVICES	Status
5. Anesthetics (as indicated)	
a. ketamine	
b. propofol	
6. Sedatives (prior to procedure, as indicated)	
a. midazolam	
b. diphenhydramine	
7. Antibiotics	
a. cotrimoxazole (as indicated)	
b. ceftriaxone (as indicated)	
c. ceftazidime (as indicated)	
d. amikacin (as indicated)	
e. Other antibiotics 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)	