



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

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[www.philhealth.gov.ph](http://www.philhealth.gov.ph)



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

Annex "C3 – ALL"

**CHECKLIST OF MANDATORY AND OTHER SERVICES**  
**Acute Lymphocytic/Lymphoblastic Leukemia (Standard Risk)**  
**After 8<sup>th</sup> Maintenance Cycle**  
**Tranche 3**

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>

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

MANDATORY AND OTHER SERVICES	Status
A. Diagnostics	
1. CSF Analysis WBC differential count	
2. CBC with platelet count	
3. Chest X-ray (as indicated)	
4. Bone marrow aspirate examination, as needed	
5. Alanine aminotransferase (ALT), as needed	
6. Creatinine, as needed	
7. Bilirubin, as needed	
8. Amylase, as needed	
9. Cranial CT scan, as needed	
10. CSF cytospin, as needed	
11. Minimal residual disease by flow cytometry, as needed	

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

<b>MANDATORY AND OTHER SERVICES</b>	<b>Status</b>
<b>B. Complete list of medicines given</b>	
1. Chemotherapy	
a. Systemic	
i. vincristine	
ii. doxorubicin (as indicated)	
iii. methotrexate (oral)	
iv. 6-mercaptopurine	
b. Intrathecal	
i. Single (methotrexate) OR	
ii. Triple (methotrexate, cytarabine, hydrocortisone)	
2. Other drugs (as indicated)	
a. dexamethasone	
b. prednisone	
3. Anti-emetics (as indicated)	
a. ondansetron	
b. metoclopramide	
4. Antibiotics (as indicated)	
a. cotrimoxazole	
b. ceftriaxone	
c. ceftazidime	
d. amikacin	
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)			