

Annex C.6: Checklist of Mandatory and Other Services for Surveillance



Republic of the Philippines
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Case No. _____

CHECKLIST OF MANDATORY AND OTHER SERVICES Breast Cancer – Surveillance

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
	2. PhilHealth ID Number <input type="text"/> - <input type="text"/> - <input type="text"/>	
B. MEMBER	(Answer only if the patient is a dependent; otherwise, write, "same as above")	
	1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number <input type="text"/> - <input type="text"/> - <input type="text"/>	

Place a (✓) in the appropriate tick box.

Laterality and Clinical Staging ^a	
<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> cStage 0	<input type="checkbox"/> cStage 0
<input type="checkbox"/> cStage IA	<input type="checkbox"/> cStage IA
<input type="checkbox"/> cStage IB	<input type="checkbox"/> cStage IB
<input type="checkbox"/> cStage IIA	<input type="checkbox"/> cStage IIA
<input type="checkbox"/> cStage IIB	<input type="checkbox"/> cStage IIB
<input type="checkbox"/> cStage IIIA	<input type="checkbox"/> cStage IIIA
<input type="checkbox"/> cStage IIIB	<input type="checkbox"/> cStage IIIB
<input type="checkbox"/> cStage IIIC	<input type="checkbox"/> cStage IIIC
<input type="checkbox"/> cStage IV	<input type="checkbox"/> cStage IV

^a If bilateral, tick in the appropriate box both laterality and its corresponding clinical staging

Place a (✓) in the appropriate tick box

Basic Services	
<input type="checkbox"/> Mammography (contralateral if mastectomy or bilateral, if lumpectomy) ^c AND/OR	Date conducted (mm/dd/yyyy): _____
<input type="checkbox"/> Ultrasound breast ^e or whole ^d abdomen AND/OR	Date conducted (mm/dd/yyyy): _____
<input type="checkbox"/> Gynecological evaluation and Transvaginal ultrasound ^f AND/OR	Date conducted (mm/dd/yyyy): _____
<input type="checkbox"/> Chest X-Ray ^b AND/OR	Date conducted (mm/dd/yyyy): _____
<input type="checkbox"/> Clinical Consultation ^a	Date of Consultation (mm/dd/yyyy): _____



Specific Services	
<input type="checkbox"/> 2D echo ^g AND/OR	Date conducted (mm/dd/yyyy): _____
<input type="checkbox"/> Bone densitometry ^h AND/OR	Date conducted (mm/dd/yyyy): _____
<input type="checkbox"/> Bone scan ⁱ	Date conducted (mm/dd/yyyy): _____

Rules on surveillance

a Clinical consultation after completion of treatment, every 3-4 months for 1st 3 years particularly for high risk patients (Stage IIB-IIIC) then once every year if asymptomatic; every month if Stage IV.

b Chest X-ray once a year, as needed

c Can be availed of post-surgery, as needed, maximum of one (1) availment per year

d Ultrasound of whole abdomen, once a year, if needed

e Ultrasound of breast, once a year, if needed

f Gynecological exam and transvaginal ultrasound, once a year if on hormonotherapy

g 2D echo, as per cardiology advice, once a year, after completion of treatment cycle of doxorubicin or trastuzumab

h Bone densitometry, once a year if on aromatase inhibitor

i Bone scan, as needed, once a year if symptomatic

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