

Annex F: Breast Cancer Treatment Passport



Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
 Citystate Centre, 709 Shaw Boulevard, Pasig City
 (02) 8662-2588 www.philhealth.gov.ph
 PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		AGE: _____
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
	2. PhilHealth ID Number □□ - □□□□□□□□□□ - □	
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 □□ - □□□□□□□□□□ - □		

Breast Cancer Treatment Passport

A. Cytotoxic Chemotherapy

Name of Drug		Dosage	Preparation	Date Initiated (mm/dd/yyyy)	Patient/ Parent/ Guardian's Signature	Attending Physician's signature
Generic Name	Brand Name					
1.						
2.						
3.						
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16.						



B. Hormonotherapy

Name of Drug		Dosage	Preparation	Date Given (mm/dd/yyyy)	Patient/ Parent/ Guardian's Signature	Attending Physician's signature
Generic Name	Brand Name					
1.						
2.						
3.						
4.						
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12.						

C. Targeted Therapy

Name of Drug		Dosage	Preparation	Date Given (mm/dd/yyyy)	Patient/ Parent/ Guardian's Signature	Attending Physician's signature
Generic Name	Brand Name					
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