

# Annex M: Breast Cancer Medical Records Summary Form



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

## BREAST CANCER MEDICAL RECORDS SUMMARY FORM

**Instructions:** This form is required for all breast cancer mortalities and “lost to follow-up<sup>1</sup>” patients in contracted health facilities. Completely fill-out all required items. Submit this form as attachment to claims for the specific treatment phase, as applicable.

### I. Breast Cancer Disease Profile

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                 |
|----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Laterality of breast cancer (Choose one by ticking the appropriate box)                | <input type="checkbox"/> Right<br><input type="checkbox"/> Left<br><input type="checkbox"/> Both<br><input type="checkbox"/> Not recorded in the chart                                                                                                                                                                                                                                                          |
| Biopsy Histological Diagnosis (Verbatim from histopathology report)                    |                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Date of biopsy                                                                         | Date (mm/dd/yyyy)                                                                                                                                                                                                                                                                                                                                                                                               |
| Clinical Cancer Stage at pre-authorization (Choose one by ticking the appropriate box) | <input type="checkbox"/> cStage 0<br><input type="checkbox"/> cStage IA<br><input type="checkbox"/> cStage IB<br><input type="checkbox"/> cStage IIA<br><input type="checkbox"/> cStage IIB<br><input type="checkbox"/> cStage IIIA<br><input type="checkbox"/> cStage IIIB<br><input type="checkbox"/> cStage IIIC<br><input type="checkbox"/> cStage IV<br><input type="checkbox"/> Not recorded in the chart |



|                                                                                           |                                                      |
|-------------------------------------------------------------------------------------------|------------------------------------------------------|
| TNM (Choose one by ticking the appropriate box)                                           | <input type="checkbox"/> With data                   |
|                                                                                           | <input type="checkbox"/> Not recorded in the chart   |
| If with data on TNM:                                                                      | What is T?                                           |
|                                                                                           | What is N?                                           |
|                                                                                           | What is M?                                           |
| Widest diameter size of primary tumor                                                     | (cm) _____ or _____ (mm)                             |
|                                                                                           | Not recorded in the chart                            |
| Skin ulceration (Choose one by checking the appropriate box)                              | <input type="checkbox"/> Yes                         |
|                                                                                           | <input type="checkbox"/> No                          |
|                                                                                           | <input type="checkbox"/> Not recorded in the chart   |
| Skin satellite lesion/s (Choose one by checking the appropriate box)                      | <input type="checkbox"/> Yes                         |
|                                                                                           | <input type="checkbox"/> No                          |
|                                                                                           | <input type="checkbox"/> Not recorded in the chart   |
| Multifocal carcinomata (Choose one by checking the appropriate box)                       | <input type="checkbox"/> Yes                         |
|                                                                                           | <input type="checkbox"/> No                          |
|                                                                                           | <input type="checkbox"/> Not recorded in the chart   |
| Regional lymph node involvement (Choose one by checking the appropriate box)              | <input type="checkbox"/> Yes                         |
|                                                                                           | <input type="checkbox"/> No                          |
|                                                                                           | <input type="checkbox"/> Not recorded in the chart   |
| Distant metastasis (Choose one by checking the appropriate box)                           | <input type="checkbox"/> Yes                         |
|                                                                                           | <input type="checkbox"/> No                          |
|                                                                                           | <input type="checkbox"/> Not recorded in the chart   |
| If yes, when did first metastasis happen?                                                 | <input type="checkbox"/> Date (mm/dd/yyyy)           |
|                                                                                           | <input type="checkbox"/> Not recorded in the chart   |
| If yes, which organ site/s? (Can choose more than one by checking the appropriate box/es) | <input type="checkbox"/> Regional lymph nodes        |
|                                                                                           | <input type="checkbox"/> Brain                       |
|                                                                                           | <input type="checkbox"/> Skin                        |
|                                                                                           | <input type="checkbox"/> Lung                        |
|                                                                                           | <input type="checkbox"/> Pleura                      |
|                                                                                           | <input type="checkbox"/> Liver                       |
|                                                                                           | <input type="checkbox"/> Adrenal                     |
|                                                                                           | <input type="checkbox"/> Bone                        |
|                                                                                           | <input type="checkbox"/> Peritoneum                  |
|                                                                                           | <input type="checkbox"/> Pelvic                      |
|                                                                                           | <input type="checkbox"/> Adjacent Organ/s (Specify): |
|                                                                                           | <input type="checkbox"/> Others (Specify):           |
| Post-surgical histological diagnosis (Verbatim from pathological report)                  |                                                      |

|                                                                            |                                                                             |
|----------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| Date of post-surgical histopathologic report                               | (mm/dd/yyyy)                                                                |
| Histological/nuclear grade<br>(Choose one by checking the appropriate box) | <input type="checkbox"/> GX: Grade cannot be assessed (undetermined grade)  |
|                                                                            | <input type="checkbox"/> G1: well-differentiated (low grade)                |
|                                                                            | <input type="checkbox"/> G2: moderately differentiated (intermediate grade) |
|                                                                            | <input type="checkbox"/> G3: poorly differentiated (high grade)             |
|                                                                            | <input type="checkbox"/> G4: undifferentiated (high grade)                  |
|                                                                            | <input type="checkbox"/> Not recorded in the chart                          |
| Pathological Cancer Stage (Choose one by checking the appropriate box)     | <input type="checkbox"/> cStage 0                                           |
|                                                                            | <input type="checkbox"/> cStage IA                                          |
|                                                                            | <input type="checkbox"/> cStage IB                                          |
|                                                                            | <input type="checkbox"/> cStage IIA                                         |
|                                                                            | <input type="checkbox"/> cStage IIB                                         |
|                                                                            | <input type="checkbox"/> cStage IIIA                                        |
|                                                                            | <input type="checkbox"/> cStage IIIB                                        |
|                                                                            | <input type="checkbox"/> cStage IIIC                                        |
|                                                                            | <input type="checkbox"/> cStage IV                                          |
|                                                                            | <input type="checkbox"/> Not recorded in the chart                          |
| Provide the appropriate information for TNM                                | What is T?                                                                  |
|                                                                            | What is N?                                                                  |
|                                                                            | What is M?                                                                  |
|                                                                            | <input type="checkbox"/> Not recorded in the chart                          |
| Widest diameter of primary tumor                                           | _____ (cm) or _____ (mm)                                                    |
|                                                                            | <input type="checkbox"/> Not recorded in the chart                          |
| Number of positive lymph nodes/TLNs harvested                              | __ positive lymph nodes                                                     |
|                                                                            | __ TLNs                                                                     |
| Lymphovascular invasion (Choose one by checking the appropriate box)       | <input type="checkbox"/> Negative                                           |
|                                                                            | <input type="checkbox"/> Positive                                           |
|                                                                            | <input type="checkbox"/> Not recorded in the chart                          |
| Perineural invasion (Choose one by checking the appropriate box)           | <input type="checkbox"/> Negative                                           |
|                                                                            | <input type="checkbox"/> Positive                                           |
|                                                                            | <input type="checkbox"/> Not recorded in the chart                          |
| Surgical margin involvement (Choose one by checking the appropriate box)   | <input type="checkbox"/> Negative                                           |
|                                                                            | <input type="checkbox"/> Positive                                           |
|                                                                            | <input type="checkbox"/> Not recorded in the chart                          |
| Were tumor markers done? (Choose one by checking the appropriate box)      | <input type="checkbox"/> Yes                                                |
|                                                                            | <input type="checkbox"/> No                                                 |
|                                                                            | <input type="checkbox"/> Not recorded in the chart                          |
| ER (Choose one by checking the appropriate box)                            | <input type="checkbox"/> Negative                                           |
|                                                                            | <input type="checkbox"/> Positive: __% (1% to 100%); Alfred score __        |
|                                                                            | <input type="checkbox"/> Not recorded in the chart                          |
| PR (Choose one by checking the appropriate box)                            | <input type="checkbox"/> Negative                                           |
|                                                                            | <input type="checkbox"/> Positive: __% (1% to 100%); Alfred score __        |
|                                                                            | <input type="checkbox"/> Not recorded in the chart                          |

|                                                                                |                                                    |
|--------------------------------------------------------------------------------|----------------------------------------------------|
| Her2neu IHC staining intensity<br>(Choose one by checking the appropriate box) | <input type="checkbox"/> Negative                  |
|                                                                                | <input type="checkbox"/> Positive                  |
|                                                                                | <input type="checkbox"/> Equivocal                 |
|                                                                                | <input type="checkbox"/> Not recorded in the chart |
| Her2neu gene amplification (Choose one by checking the appropriate box)        | <input type="checkbox"/> Non-amplified             |
|                                                                                | <input type="checkbox"/> Amplified                 |
|                                                                                | <input type="checkbox"/> Not recorded in the chart |

## II. Breast Cancer Treatment Profile

|                                                                                                                    |                                                                                    |
|--------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| Was definitive surgery done? (Choose one by checking the appropriate box)                                          | <input type="checkbox"/> Yes                                                       |
|                                                                                                                    | <input type="checkbox"/> No                                                        |
|                                                                                                                    | <input type="checkbox"/> No operative record in the chart                          |
| If yes, what is the name of the surgical procedure?                                                                |                                                                                    |
| Was chemotherapy given in the contracted health facilities? (Choose one by checking the appropriate box)           | <input type="checkbox"/> Yes                                                       |
|                                                                                                                    | <input type="checkbox"/> No                                                        |
|                                                                                                                    | <input type="checkbox"/> No record found in the contracted health care institution |
|                                                                                                                    | <input type="checkbox"/> Chemotherapy was given by another healthcare provider     |
| If answer to previous question is “no,” check the appropriate box and must provide details.                        | <input type="checkbox"/> Patient preference                                        |
|                                                                                                                    | <input type="checkbox"/> Advised by healthcare provider                            |
|                                                                                                                    | <input type="checkbox"/> Patient is “lost to follow-up <sup>1</sup> ”              |
| If answer is “yes,” specify the drug regimen used.                                                                 |                                                                                    |
| Specify the total dose per cycle for the drug regimen used (Choose one by checking the appropriate box)            | <input type="checkbox"/> Total dose per cycle: _____                               |
|                                                                                                                    | <input type="checkbox"/> Not recorded in the chart                                 |
| If chemotherapy was given, provide the date when chemotherapy started (Choose one by checking the appropriate box) | <input type="checkbox"/> mm/dd/yyyy _____                                          |
|                                                                                                                    | <input type="checkbox"/> Not recorded in the chart                                 |
|                                                                                                                    | <input type="checkbox"/> NA, chemotherapy was not given                            |
| If chemotherapy was given, how many cycles were given? (Choose one by checking the appropriate box)                | <input type="checkbox"/> ____                                                      |
|                                                                                                                    | <input type="checkbox"/> NA, chemotherapy was not given                            |

|                                                                                                        |                                                                                                                                                                                                                                                                                                                                                   |
|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the purpose of chemotherapy?<br>(Choose one by checking the appropriate box)                   | <input type="checkbox"/> Adjuvant<br><input type="checkbox"/> Neo-adjuvant<br><input type="checkbox"/> NA, chemotherapy was not given                                                                                                                                                                                                             |
| What is tumor response to chemotherapy?<br>(Choose one by checking the appropriate box)                | <input type="checkbox"/> NED (no evidence of disease progression)<br><input type="checkbox"/> CR<br><input type="checkbox"/> PR<br><input type="checkbox"/> SD<br><input type="checkbox"/> PD (progressive disease)<br><input type="checkbox"/> Not recorded in the chart<br><input type="checkbox"/> NA, chemotherapy was not given              |
| Was the chemotherapy regimen ever changed?                                                             | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not recorded in the chart<br><input type="checkbox"/> NA, chemotherapy was not given                                                                                                                                                                      |
| What is reason for chemotherapy regimen is changed?                                                    | <input type="checkbox"/> Adverse event to former chemotherapy. Specify adverse event: _____<br><br><input type="checkbox"/> PD<br><input type="checkbox"/> Patient preference<br><input type="checkbox"/> Other (Specify): _____<br><input type="checkbox"/> Not recorded in the chart<br><input type="checkbox"/> NA, chemotherapy was not given |
| What drug/s were used in this new chemotherapy regimen?                                                |                                                                                                                                                                                                                                                                                                                                                   |
| Specify the total dose per drug per cycle for this new drug regimen used                               | <input type="checkbox"/> Total dose per drug per cycle: _____<br><br><input type="checkbox"/> Not recorded in the chart                                                                                                                                                                                                                           |
| What is the start date for this new chemotherapy regimen?                                              | mm/dd/yyyy                                                                                                                                                                                                                                                                                                                                        |
| How many cycles were given for this new chemotherapy regimen?                                          |                                                                                                                                                                                                                                                                                                                                                   |
| What is the purpose for this new chemotherapy regimen?                                                 | <input type="checkbox"/> Adjuvant<br><input type="checkbox"/> Neo-adjuvant<br><input type="checkbox"/> Palliative<br><input type="checkbox"/> Not recorded in the chart                                                                                                                                                                           |
| What is tumor response for this new chemotherapy regimen? (Choose one by checking the appropriate box) | <input type="checkbox"/> NED<br><input type="checkbox"/> CR<br><input type="checkbox"/> PR<br><input type="checkbox"/> SD<br><input type="checkbox"/> PD<br><input type="checkbox"/> Not recorded in the chart                                                                                                                                    |
| Was radiotherapy advised?                                                                              | <input type="checkbox"/> Yes, it is recorded in the chart<br><input type="checkbox"/> No, it is recorded in the chart<br><input type="checkbox"/> It is not documented in the chart                                                                                                                                                               |

|                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
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| If RT was advised, was radiotherapy given?                                                                       | <input type="checkbox"/> Yes, it is recorded in the chart<br><input type="checkbox"/> No, it is recorded in the chart<br><input type="checkbox"/> It is not documented in the chart                                                                                                                                                                                                                                                                                                                                                                  |
| Was supportive care given?                                                                                       | <input type="checkbox"/> Yes, it is recorded in the chart<br><input type="checkbox"/> No, it is recorded in the chart<br><input type="checkbox"/> It is not documented in the chart                                                                                                                                                                                                                                                                                                                                                                  |
| If answer is “yes,” specify supportive care (May choose more than one)                                           | <input type="checkbox"/> Pain control (Specify): _____<br><input type="checkbox"/> Nutrition build-up<br><input type="checkbox"/> Rehabilitation from a sequela of the treatment<br><input type="checkbox"/> Psychological counseling<br><input type="checkbox"/> Psychiatric intervention<br><input type="checkbox"/> Religious/faith counseling<br><input type="checkbox"/> Referral to Civil Society Organization<br><input type="checkbox"/> NA, supportive care was not given<br><input type="checkbox"/> NA, it is not documented in the chart |
| Was the hormonotherapy given to the contracted health facilities? (Choose one by checking the appropriate box)   | <input type="checkbox"/> Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                  | <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                  | <input type="checkbox"/> No record was found in the contracted health facility                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                  | <input type="checkbox"/> Hormonotherapy was given by another healthcare provider                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| If the answer to the previous question is “no,” check the appropriate box and must provide details.              | <input type="checkbox"/> Patient preference<br><input type="checkbox"/> Advised by a healthcare provider<br><input type="checkbox"/> Patient is “lost to follow-up <sup>1</sup> ”                                                                                                                                                                                                                                                                                                                                                                    |
| If the answer is “yes,” specify the drug regimen used.                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Specify the total number of prescriptions for the drug regimen used (Choose one by checking the appropriate box) | <input type="checkbox"/> Total prescription: _____<br><input type="checkbox"/> Not recorded in the chart                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| If hormonotherapy was given, provide the date when it was started (Choose one by checking the appropriate box)   | <input type="checkbox"/> mm/dd/yyyy _____<br><input type="checkbox"/> Not recorded in the chart<br><input type="checkbox"/> NA, hormonotherapy was not given                                                                                                                                                                                                                                                                                                                                                                                         |
| What is the purpose of hormonotherapy? (Choose one by checking the appropriate box)                              | <input type="checkbox"/> Premenopausal<br><input type="checkbox"/> Postmenopausal<br><input type="checkbox"/> NA, hormonotherapy was not given                                                                                                                                                                                                                                                                                                                                                                                                       |
| Was the targeted therapy given to the contracted health facilities? (Choose one by checking the appropriate box) | <input type="checkbox"/> Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                  | <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                  | <input type="checkbox"/> No record found in the contracted health facility                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

|                                                                                                                  |                                                                                                                                                                                 |
|------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                  | <input type="checkbox"/> Targeted therapy was given by Another healthcare provider                                                                                              |
| If answer to previous question is “no,” check the appropriate box and must provide details.                      | <input type="checkbox"/> Patient preference<br><input type="checkbox"/> Advised by healthcare provider<br><input type="checkbox"/> Patient is “lost to follow-up <sup>1</sup> ” |
| If answer is “yes,” specify the drug regimen used.                                                               |                                                                                                                                                                                 |
| Specify the total dose per cycle for the drug regimen used (Choose one by checking the appropriate box)          | <input type="checkbox"/> Total dose per cycle: _____<br><input type="checkbox"/> Not recorded in the chart                                                                      |
| If targeted therapy was given, provide the date when it was started (Choose one by checking the appropriate box) | <input type="checkbox"/> mm/dd/yyyy _____<br><input type="checkbox"/> Not recorded in the chart<br><input type="checkbox"/> NA, targeted therapy was not given                  |
| If targeted therapy was given, how many cycles were given? (Choose one by checking the appropriate box)          | <input type="checkbox"/> _____<br><input type="checkbox"/> NA, targeted therapy was not given                                                                                   |

### III. Breast Cancer Survival Status

|                                                                 |                                                                                                                                                     |
|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|
| Date of survival assessment                                     | mm/dd/yyyy                                                                                                                                          |
| What is the status of this patient at this date                 | <input type="checkbox"/> Alive                                                                                                                      |
|                                                                 | <input type="checkbox"/> Died                                                                                                                       |
|                                                                 | <input type="checkbox"/> Lost to follow-up <sup>1</sup>                                                                                             |
|                                                                 | <input type="checkbox"/> Not recorded in the chart                                                                                                  |
| When was date of last follow-up?                                | <input type="checkbox"/> mm/dd/yyyy<br><input type="checkbox"/> Not recorded in the chart                                                           |
| What is the status of this patient at this last follow-up date? | <input type="checkbox"/> Alive, NED                                                                                                                 |
|                                                                 | <input type="checkbox"/> Alive with residual small lesions, on definitive treatment                                                                 |
|                                                                 | <input type="checkbox"/> Alive with residual small lesions, without definitive treatment                                                            |
|                                                                 | <input type="checkbox"/> Alive with residual big lesions, on definitive treatment                                                                   |
|                                                                 | <input type="checkbox"/> Alive with residual big lesions, without definitive treatment                                                              |
|                                                                 | <input type="checkbox"/> Alive with terminal disease, only on supportive treatment                                                                  |
|                                                                 | <input type="checkbox"/> Not recorded in the chart                                                                                                  |
| If died, when was date of death?                                | <input type="checkbox"/> mm/dd/yyyy<br><input type="checkbox"/> Not recorded in the chart                                                           |
| If died, what is cause of death?                                | <input type="checkbox"/> Breast cancer-related<br><input type="checkbox"/> Not cancer-related<br><input type="checkbox"/> Not recorded in the chart |

<sup>1</sup> Lost to follow-up refers to a term used to characterize a breast cancer patient who has not returned to or followed up at a contracted health facility after sixty (60) calendar days from the scheduled visit or treatment, as advised.