Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "C1 – CABG"

HEALTHCARE *PROVIDER (HCP)*		
ADDRESS OF *HCP*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	*SEX* ☐ *Male* ☐ *Female*
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	☐ *Same as patient* *(Answer the following only if the patient is a dependent)* 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF MANDATORY and OTHER SERVICES
Standard Risk Elective Coronary Artery Bypass Graft Surgery (CABG) – Tranche 1

Place a (✓) in the appropriate tick box if *the service is* done *or* given.

MANDATORY SERVICES	OTHER SERVICES as needed/ as indicated
Preoperative laboratory tests such as :	
☐ CBC	
☐ Platelet count	
☐ Blood typing	
☐ Na	
☐ K	
☐ Mg	
☐ Calcium	
☐ FBS	
☐ BUN	
☐ Creatinine	
☐ Chest X-ray (PA/lateral)	
☐ 12-lead ECG	
☐ Room air arterial blood gas	
☐ Protime-INR	
☐ Plasma thromboplastin time	
Medications	**Tick appropriate box if not given**
☐ Beta blocker OR calcium antagonist	☐ contraindicated ☐ will cause adverse reaction
☐ Statin	☐ contraindicated ☐ will cause adverse reaction
☐ Ace inhibitor OR ARB	☐ contraindicated ☐ will cause adverse reaction
☐ Aspirin OR anti-platelet	☐ contraindicated ☐ will cause adverse reaction
☐ Preoperative antibiotic prophylaxis	☐ contraindicated ☐ will cause adverse reaction

Place a (✓) in the appropriate tick box if *the service is* done *or* given.

MANDATORY SERVICES	OTHER SERVICES as needed/ as indicated
☐ Open heart surgery under general anesthesia	
☐ Immediate postoperative care at surgical ICU	
	☐ Blood bank screening and blood products, as indicated
	☐ *Continuing postoperative care*
	☐ Additional laboratory tests
	☐ Postoperative antibiotics (IV and oral)
Treatments	
☐ *Incentive spirometry*	
	☐ VTE Prophylaxis
	☐ Nebulization with medications such as beta agonist + steroid or salbutamol/pulmonary physiotherapy
	☐ Blood glucose monitoring
	☐ Wound dressings/wound care
	☐ Renal replacement therapy
	☐ Other medications, specify: _____ _____
	☐ Pulmonary care, as indicated, such as ventilator support; nebulization with a beta 2 agonist *alone or* with steroid *or anticholinergic combinations*
	☐ Other specialty services as needed, such as pulmonology, nephrology, neurology, infectious disease, etc.

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Cardiologist	(Printed name and signature) Attending Cardiovascular Surgeon
PhilHealth Accreditation No. ☐☐☐☐–☐☐☐☐☐☐☐–☐	PhilHealth Accreditation No. ☐☐☐☐–☐☐☐☐☐☐☐–☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

HEALTHCARE *PROVIDER (HCP)*		
ADDRESS OF *HCP*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	☐ *Same as patient* *(Answer the following only if the patient is a dependent)* 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

Certified correct by:	Certified correct by:
(Printed name and signature) Anesthesiologist	(Printed name and signature) Authorized Blood Bank Staff
PhilHealth Accreditation No. ☐☐☐☐ – ☐☐☐☐☐☐☐☐ – ☐	PRC License No. ☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient/Guardian
Date signed (mm/dd/yyyy)