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

Case No. _____

Annex "C1.1 – Cervical CA"

HEALTH CARE *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
Surgery for Cervical Cancer Stage IA1, IA2-IIA1

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

MANDATORY SERVICES	OTHER SERVICES as needed/ as indicated
Preoperative Laboratory:	
☐ CBC	☐ Partial thromboplastin time
☐ Platelet count	☐ CT scan or MRI
☐ Blood typing	☐ Blood support (screening, processing)
☐ Chest X-ray	☐ Cystoscopy
☐ ECG	
☐ FBS	
☐ Na, K, Cl, Ca	
☐ Creatinine	
☐ AST/ALT	
☐ Pro-time	
☐ Urinalysis	
☐ Histopathology	
☐ TV-UTZ	
☐ Preoperative antibiotic prophylaxis	
	☐ Procedure done Date of procedure: (mm/dd/yyyy)_____ **For Stage IA1 alone:** Extrafascial/Total Hysterectomy with or without bilateral salpingoophorectomy **For stage 1A2 -1B1**: Radical Hysterectomy with bilateral pelvic lymphadenectomy, paraortic lymph node sampling

MANDATORY SERVICES	OTHER SERVICES as needed/ as indicated
	(Tick appropriate box; choose one) ☐ bilateral salpingoophorectomy ☐ transposition of ovaries
	☐ Blood transfusion support
	Postoperative laboratory
	☐ CBC with platelet
	☐ ECG
	☐ Electrolytes
	Postoperative medications
	☐ Analgesics
	☐ Antibiotics
	☐ Hematinics

Certified correct by:	Certified correct by:
(Printed name and signature) Gynecologic Oncologist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No.	PhilHealth Accreditation No.
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient