

Case No.

## Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION

UNIVERSAL HEALTH CARE
KAUSUGAN AT KAUNGA PANA SA LAHAT

Citystate Centre, 709 Shaw Boulevard, Pasig City Call Center: (02) 8441-7442 | Trunkline: (02) 8441-7444 www.philhealth.gov.ph

		Annex "C1.2 – Cervical CA"			
HEALTH CA	RE PROVIDER (HCP)				
ADDRESS OF	F 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				
	1. Last Name, First Name, Suffix	, Middle Name			
	2. PhilHealth ID Number	<u> </u>			
Chemora	CHECKLIST OF MANDATO	RY and OTHER SERVICES therapy (Low Dose) for Cervical Cancer			
		,			
Place a (♥) in t	the appropriate tick box if the service	OTHER SERVICES			
MAN	DATORY SERVICES	as needed/ as indicated			
Preoperative L	aboratory:				
□ CBC	,	☐ Partial thromboplastin time			
☐ Platelet	count	☐ CT scan or MRI			
☐ Blood t		☐ Blood support (screening, processing)			
☐ Chest ∑	71 0	☐ Cystoscopy			
□ ECG	A	☐ Proctosigmoidoscopy			
□ FBS		8 17			
□ Na, K,	Cl, Ca				
☐ Creatin					
□ AST/A					
☐ Pro-tim					
☐ Urinaly					
	athology				
□ TV-UT	C,				
		☐ Blood transfusion Support			
Radiation Trea	tment Summary	Date of Procedure			
☐ Pelvic cobalt radiation		(start mm/dd/yyyy –end mm/dd/yyyy):			
☐ Low dose brachytherapy ☐ Dates of Procedure (mm/dd/yyyy):					
1					



MANDATORY SERVICES					
Chemotherapy medications (Check only one chemotherapy per cycle)					
	Cycle	Cisplatin	Carboplatin	Others: (specify)	Remarks
	I			, , , , ,	
	II				
	III				
	137	·		·	

Chemotherapy Treatment Summary

VI

Cycle	Date (mm/dd/yyyy) Remarks				
I					
II					
III					
IV	West State of the				
V					
VI	All and a second				

## **OTHER SERVICES**

Pre chemotherapy laboratory exams per cycle

Cycle	СВС	Creatinine	Mg	Urinalysis
I				
II				
III				
IV				
V				
VI				

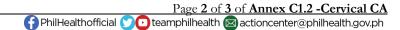
Support medications

Cycle	Anti-emetics	G-CSF	Hematinics	Others: specify
I				
II				
III				
IV				
V				
VI				

Post treatment Medications (home medications)

Cycle	Anti-emetics	Analgesics	Hematinics	Others: specify
I				
II				
III				
IV				
V				
VI				





HEALTH CARE PROVIDER (HCP)					
ADDRESS OF HCP					
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix $SEX \square Male \square M$				
	2. PhilHealth ID Number	-	-		
B. MEMBER	☐ Same as patient (Answer the following only if the patient is a dependent)  1. Last Name, First Name, Middle Name, Suffix				
	2. PhilHealth ID Number	-			
Certified correc	ct by:	Certified correct by:			
(Printed name and signature) Gynecologic Oncologist		(Printed name and signature) Radiation Oncologist			
PhilHealth Accreditation No.	- PhilHealth Accreditation No.		-		
Date signed (m	nm/dd/yyyy)	Date signed (mm/dd/yy	yy)		
Conforme by:		Certified correct by:			
(Printed name and signature)		(Printed name and signature)			
Patient		Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief			
Date signed (mm/dd/yyyy)		PhilHealth Accreditation No.	-		
		Date signed (mm/dd/yyy	y)		

