



Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex “C1.2 – Cervical CA”

HEALTH CARE PROVIDER (HCP)		
ADDRESS OF HCP		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
	2. PhilHealth ID Number	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>
B. MEMBER	<input type="checkbox"/> 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	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>

CHECKLIST OF MANDATORY and OTHER SERVICES
Chemoradiation with Cobalt and Brachytherapy (Low Dose) for Cervical Cancer

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

MANDATORY SERVICES	OTHER SERVICES as needed/ as indicated	
Preoperative Laboratory:		
<input type="checkbox"/> CBC	<input type="checkbox"/> Partial thromboplastin time	
<input type="checkbox"/> Platelet count	<input type="checkbox"/> CT scan or MRI	
<input type="checkbox"/> Blood typing	<input type="checkbox"/> Blood support (screening, processing)	
<input type="checkbox"/> Chest X-ray	<input type="checkbox"/> Cystoscopy	
<input type="checkbox"/> ECG	<input type="checkbox"/> Proctosigmoidoscopy	
<input type="checkbox"/> FBS		
<input type="checkbox"/> Na, K, Cl, Ca		
<input type="checkbox"/> Creatinine		
<input type="checkbox"/> AST/ALT		
<input type="checkbox"/> Pro-time		
<input type="checkbox"/> Urinalysis		
<input type="checkbox"/> Histopathology		
<input type="checkbox"/> TV-UTZ		
		<input type="checkbox"/> Blood transfusion Support
Radiation Treatment Summary		Date of Procedure (start mm/dd/yyyy –end mm/dd/yyyy): _____
<input type="checkbox"/> Pelvic cobalt radiation		
<input type="checkbox"/> Low dose brachytherapy	Dates of Procedure (mm/dd/yyyy): _____ _____ _____ _____	



Revised as of November 2021

MANDATORY SERVICES

Chemotherapy medications (Check only one chemotherapy per cycle)

Cycle	Cisplatin	Carboplatin	Others: (specify)	Remarks
I				
II				
III				
IV				
V				
VI				

Chemotherapy Treatment Summary

Cycle	Date (mm/dd/yyyy)	Remarks
I		
II		
III		
IV		
V		
VI		

OTHER SERVICES

Pre chemotherapy laboratory exams per cycle

Cycle	CBC	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 <input type="checkbox"/> Male <input type="checkbox"/> Female
	2. PhilHealth ID Number	<input type="text"/> - <input type="text"/> - <input type="text"/>
B. MEMBER	<input type="checkbox"/> 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	<input type="text"/> - <input type="text"/> - <input type="text"/>

Certified correct by:		Certified correct by:	
(Printed name and signature) Gynecologic Oncologist		(Printed name and signature) Radiation Oncologist	
PhilHealth Accreditation No.	<input type="text"/> - <input type="text"/>	PhilHealth Accreditation No.	<input type="text"/> - <input type="text"/>
Date signed (mm/dd/yyyy)		Date signed (mm/dd/yyyy)	

Conforme by:		Certified correct by:	
(Printed name and signature) Patient		(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief	
Date signed (mm/dd/yyyy)		PhilHealth Accreditation No.	<input type="text"/> - <input type="text"/>
		Date signed (mm/dd/yyyy)	

