Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 Trunkline (02) 441-7444
www.philhealth.gov.ph

Case No. _______________

Annex "C1.2 – Cervical CA"

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

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

Place a (✓) in the status column if DONE or GIVEN.

MANDATORY SERVICES	Status
1. Preoperative Laboratory:	
a. CBC	
b. Platelet count	
c. Blood typing	
d. Chest X-ray	
e. ECG	
f. FBS	
g. Na, K, Cl, Ca	
h. Creatinine	
i. AST/ALT	
j. Pro-time	
k. Partial Thromboplastin Time, as needed	
l. Urinalysis	
m. Histopathology	
n. Imaging:	
n.1. TV-UTZ	
n.2. CT Scan, as needed or MRI, as needed	
o. Blood support, as needed (screening, processing)	
p. Cystoscopy, as needed	
q. Proctosigmoidoscopy, as needed	

MANDATORY SERVICES	Tick appropriate box
1. Radiation Treatment Summary a. Pelvic cobalt radiation	**Date of Procedure (start mm/dd/yyyy – end mm/dd/yyyy):** ____________________
b. Low dose brachytherapy	**Dates of Procedure (mm/dd/yyyy)** ____________________ ____________________ ____________________ ____________________

2. Pre chemotherapy laboratory exams per cycle (as indicated)

Cycle	CBC	Creatinine	Mg	Urinalysis
I				
II				
III				
IV				
V				
VI				

3. Chemotherapy medications (Check only one chemotherapy per cycle)

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

4. Support medications (as indicated)

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

Place a (✓) in the status column if DONE or GIVEN.

MANDATORY SERVICES	Status
5. Blood Transfusion Support (as indicated)	
6. Post treatment Medications (home medications, as indicated)	

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

7. Chemotherapy Treatment Summary

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

Certified correct by:	Certified correct by:
(Printed name and signature) Gynecologic Oncologist	(Printed name and signature) Radiation Oncologist
PhilHealth Accreditation No. _ _ _ _ – _ _ _ _ _ _ _ – _	PhilHealth Accreditation No. _ _ _ _ – _ _ _ _ _ _ _ – _
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. _ _ _ _ – _ _ _ _ _ _ _ – _
	Date signed (mm/dd/yyyy)