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

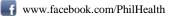
Place a (in the status column if DONE or GIVEN

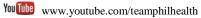
MANDATORY SERVICES	Status
1. Preoperative Laboratory:	A 1
a. CBC	1 7/
b. Platelet count	2/
c. Blood typing	
d. Chest X-ray	7/
e. ECG	
f. FBS	
g. Na, K, Cl, Ca	
h. Creatinine	
i. AST/ALT	
j. Pro-time	
k. Partial Thromboplastin Time, as needed	
l. Urinalysis	
m. Histopathology	
n. Imaging:	
n.1. TV-UTZ	
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	

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	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 laborar	forv exams per o	cycle (as indicate	d)			
 		onano per c	, iie (as iiieieate	 /			
	Cycle	CBC	Creatinine	Mg	Urinalysis		
	I						
	II			10			
	III						
	V				7/		
	VI			A	/		
	V1						
3	Chemotherapy medication	ns (Check only o	one chemothera	ny ner cycle)			
٥.	onemotierapy medicado.	iis (Gireen oilly (py per eyere)			
	Cycle	Cisplatin	Carboplatin	Others: (specify)	Remarks		
	I		1	1 1/			
	II						
	III						
	IV						
	V						
	VI						
4.	Support medications (as i	ndicated)					
	Cycle	Anti-emetics	GSF	Hematinics	Others: specify		
	I	Anti-emetics	GSI	Hematinics	Others: specify		
	II						
	III						
	IV						
	V						
	VI						
	, , ,	l	l	l			

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

MANDATORY SERVICES				Status				
5. Blood Tra	nsfusion Supp	ort (as indicated)						
6. Post treatment Medications (home medications, as indicated)								
Cycle Anti-emetics A			Analgesics	Analgesics Hematinics Othe			1	
	I	THIR CHICUCS	THIAIS COICE	110		Others: specify		
	II							
	III							
	IV							
	V							
	VI							
7. Chemothe	erapy Treatmen	et Cummany						
7. Chemotic	тару ттеаштеп	it Summary						
	Cycle	Date (mm/dd/	уууу)		Remarl	ırks		
	AI	À						
	II	13						
	III							
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Certified correct by: Certified correct by:								
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	ited name and			`		and signature)		
-	ynecologic One	cologist		Ra	diation C	Oncologist		
PhilHealth Accreditation No.			PhilHealth Accreditation	PhilHealth Accreditation No.				
Date signed (mm/dd/yyyy)			Date sig	ned (mr	n/dd/yyy	y)		
Conforme by:		Certified	Certified correct by:					
(Printed name and signature)				(Printed name and signature)				
Patient				Executive Director/Chief of Hospital/				
			Mec PhilHealth	lical Dir	ector/ M	edical Center Chi	et	
Date signed (n	nm/dd/yyyy)		Accreditation	n No.	-	1	-	
			Date sig	ned (mn	n/dd/yyy	y)	1 1	
			I					

Revised as of October 2015

