

Annex C.1.3: EMORPH Discharge Checklist: Lower Limb Orthosis

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Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

HEALTH FACILITY (HF)	
ADDRESS OF HF	
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"/> <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	(Answer only if the patient is a dependent; otherwise, write, "same as above") 1. Last Name, First Name, Middle Name, Suffix _____
	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"/>

DISCHARGE CHECKLIST FOR EXPANDED ZMORPH Lower Limb Orthosis

Tranche 1

Place a check (✓) mark

CRITERIA FOR DISCHARGE	Yes
1. External lower limb orthosis provided is as prescribed with appropriate alignment and fit	
2. The lower limb is free of blisters, vascular compromise, pain, hypersensitivity after 30 minutes of orthosis weight-bearing while standing and/or walking	
3. Lower limb orthosis allows safe ambulation with or without assistive device	
4. Orthosis user possesses competent skill and knowledge regarding donning, doffing, cleaning, precautions and falling techniques	

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

Conforme by:
(Printed name and signature) Patient/Parent/Guardian
Date signed (mm/dd/yyyy)

