Annex H: Checklist of Essential Health Services

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Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER ☐ *Same as patient* *(Answer only if the patient is a dependent)*	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF ESSENTIAL HEALTH SERVICES FOR HEART VALVE REPAIR AND/OR REPLACEMENT FOR VALVULAR HEART DISEASE

Type of Procedure or Service Place a (✔) on the type of procedure or service; and whether adult or pediatric as applicable
☐ Mitral Valve Replacement with Tricuspid Valve Annuloplasty ___ Adult ___Pediatric
☐ Aortic Valve Replacement with Tricuspid Valve Annuloplasty (Pediatric)
☐ Mitral Valve Replacement ___ Adult ___Pediatric
☐ Aortic Valve Replacement (Pediatric)
☐ Mitral and Tricuspid Valve Repair (Pediatric)
☐ Mitral Valve Repair (Pediatric)
☐ Aortic Valve Repair (Pediatric)
☐ Cardiac Rehabilitation (minimum of 4 sessions) ___ Adult ___ Pediatric

I. Laboratory Tests and Diagnostics Place a (✔) opposite appropriate answer; as applicable	
***Mandatory** ___ CBC with platelet ___ Blood typing ___ Prothrombin time ___ Activated partial thromboplastin time Electrolytes : ___ Sodium (Na) ___ Potassium (K)	___ Creatinine ___ Albumin ___ BUN ___ Urinalysis ___ Chest X-ray (PA lateral) ___ 12 lead ECG ___ Arterial blood gas (ABG) ___ CBG monitoring ___ 2DEcho with Doppler (transthoracic or

___ Ionized Calcium (iCa) ___ Magnesium (Mg) ___ Chloride (Cl)	transesophageal), intra-op transesophageal echo
***As indicated** ___ SGPT ___ SGOT	

II. Treatment and Medications Place a (✔) opposite appropriate answer; as applicable	
***Mandatory** ___ Incentive spirometry ___ Blood products screening ___ Nebulization	___ Mechanical ventilator use ___ Beta blockers specify: _____ ___ Anticoagulant specify:_____
***As indicated:** ___ Antiplatelet specify:_____	☐ Contraindicated ☐ Will cause adverse reaction
___ Statin specify: _____	☐Contraindicated ☐Will cause adverse reaction
___ Antimicrobials specify: _____	☐Contraindicated ☐Will cause adverse reaction
___ Phenoxymethylpenicillin	☐Contraindicated ☐Will cause adverse reaction
___ ACE inhibitors or ARB specify: _____	☐Contraindicated ☐Will cause adverse reaction
___ Sedation/pain specify: _____	☐Contraindicated ☐Will cause adverse reaction
___ GI medicine specify: _____	☐Contraindicated ☐Will cause adverse reaction
___ Pulmonary medicine specify: _____	☐Contraindicated ☐Will cause adverse reaction
___ Hemodynamic support specify: _____	☐Contraindicated ☐Will cause adverse reaction
___ Electrolytes specify: _____	☐Contraindicated ☐Will cause adverse reaction
___ Calcium channel blockers specify: _____	☐Contraindicated ☐Will cause adverse reaction
___ Digoxin specify: _____	☐Contraindicated ☐Will cause adverse reaction
Others specify: _____ _____ _____	

Place a (✔) in the appropriate tick box if the service is done or given		
III. Procedure Place a (✔) if the service(s) is/are done or given		**IV. Cardiac Rehabilitation Services** Place a (✔) on the appropriate tick box
Heart valve surgery		☐ Adult ☐ Pedia *Maximum of 4 sessions (Daily Assessment, Pre-rehabilitation Orientation, and Post-rehabilitation discharge instructions)
Immediate Postoperative Care at Surgical ICU (SICU)		
For heart valve replacement (mechanical valve) ☐ Prosthetic mitral valve ☐ Prosthetic aortic valve		Indicate the dates of availment of cardiac rehabilitation services (mm/dd/yyyy): Date of 1st Session:_____ ☐ Inpatient ☐ Outpatient Date of 2nd Session:_____ ☐ Inpatient ☐ Outpatient Date of 3rd Session:_____ ☐ Inpatient ☐ Outpatient Date of 4th Session:_____ ☐ Inpatient ☐ Outpatient
Applicable for heart valve replacement with tricuspid annuloplasty: Prosthetic mitral or aortic valve (mechanical valve) + Tricuspid annuloplasty ring		

Certified correct by:	Conforme by:
(Printed name and signature) **Tick the appropriate attending physician** ☐ Cardiologist or Cardiovascular Surgeon* ☐ Cardiac Rehabilitation or Physical Medicine and Rehabilitation Specialists/ Physiatrist* PhilHealth Accreditation No.	(Printed name and signature) ☐ Patient ☐ Parent ☐ Guardian
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)