Case No. _____

Annex "C1 – KT"

CHECKLIST OF MANDATORY AND OTHER SERVICES
End Stage Renal Disease requiring Kidney Transplantation (Low Risk)
Tranche 1

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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

Place a (✓) in the status column if DONE or NA if not applicable.

MANDATORY AND OTHER SERVICES	Status
A. Cardiology clearance - for donor (if indicated) and recipient	
B. Pre-transplant evaluation/labs (Phases 1, 2, 3 and 4) for donor and recipient candidates	
C. Transplantation surgery with living or deceased donor	
D. Hemodialysis or peritoneal dialysis during admission for transplantation, if indicated	
E. Immunosuppressant induction therapy, unless identical twin or zero HLA-antigen mismatch	
F. Immunologic risk- Negative tissue crossmatch between donor and recipient, primary kidney transplant, single organ transplant, PRA class 1 and 2 negative or PRA<20%; no donor specific antibody	

IMMUNOSUPPRESSION OPTIONS (choose 1, 2, 3 or 4 only)	
1. Calcineurin inhibitor + mycophenolate + prednisone with or without induction a. cyclosporine + mycophenolate motetil or mycophenolate sodium + prednisone OR b. tacrolimus + mycophenolate mofetil or mycophenolate sodium + prednisone	
2. Calcineurin inhibitor + mTOR inhibitor + prednisone with or without induction a. Low-dose cyclosporine + sirolimus + prednisone OR b. Low-dose cyclosporine + everolimus + prednisone	

IMMUNOSUPPRESSION OPTIONS (choose 1, 2, 3 or 4 only)	**Status**
3. Calcineurin inhibitor such as cyclosporine + azathioprine + prednisone with or without induction	
4. Steroid-free for zero HLA-mismatch patient or induction using rabbit antithymocyte globulin	

INDUCTION THERAPIES (choose either 1 or 2)	
1. Interleukin-2-receptor antibody (basiliximab) 20 mg IV for two doses	
2. Lymphocyte depleting agents Rabbit anti-thymocyte globulin 1.0-1.5 mg per kg per day for three doses	

ANTI-REJECTION THERAPY, if indicated Methylprednisolone 500 mg IV per day for three days	

OTHERS	
Graft renal biopsy, if indicated	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Nephrologist or Transplant Surgeon: PhilHealth Accreditation No.	(Printed name and signature) Patient/Parent/Guardian
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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

PRE-TRANSPLANT EVALUATION FORM FOR KIDNEY TRANSPLANT RECIPIENT
Attachment to Tranche 1

Please answer all questions completely and accurately. Tick appropriate boxes.

Name (Last, First, MI) _____ ☐ NBB ☐ Fixed Co-Pay

Age _____ Sex ☐ Male ☐ Female Civil Status: ☐ Single ☐ Married ☐ Widow ☐ Separated

Race _____ Hospital No. _____

Permanent Address _____

_____ Tel. No. _____

Present Address _____

_____ Tel. No. _____

Attending Nephrologist_____ Transplant Surgeon _____

Name of Donor (Last, First, MI) _____

PhilHealth ID No. ☐☐ - ☐☐☐☐☐☐☐☐☐☐ - ☐

Primary Renal Disease _____ ☐ Clinical ☐ Biopsy Proven

Duration of Dialysis _____ Mode of Dialysis ☐ None ☐ HD ☐ PD, specify_____

KT History ☐ 1st ☐ 2nd ☐ Specify, _____ ☐ Other organ grafted _____

Anemia management: ☐ BT, _____# units Date of last BT_____

☐ EPO, Dose_____

Past Medical/Social History:

☐ HPN ☐ DM ☐ Asthma ☐ Renal Stone ☐ COPD ☐ # of Previous Pregnancies

☐ CAD ☐ Stroke ☐ PVD ☐ Liver Disease ☐ Lupus

☐ Splenectomy ☐ Others, specify _____

☐ Previous Surgeries _____ ☐ Allergies _____

☐ Smoking (Pack years)_____ ☐ Alcohol Intake _____

Family history ☐ HPN ☐ DM ☐ CAD ☐ Others, specify_____

PRE-TRANSPLANT TESTS *(recent laboratory tests and indicate dates)*

Hematology (___/___/___)

*WBC_____ *Hgb_____ *Hct _____*Platelet _____*Bleeding Time _____*PT _____*PTT _____

Blood Chemistries (___/___/___)

*Crea _____ BUN_____ *FBS _____ *Chole _____ *Trig _____ *Uric Acid _____

*ALP _____ SGOT _____*SGPT _____ *Albumin _____ *Ca _____ *P _____

*K _____ *Na _____ Intact PTH _____

Urine Examination (___/___/___) Defer if patient if anuric

*Sp. Gr. _____ pH _____ Protein_____ Sugar____ Blood_____ WBC_____ RBC_____

*Urine culture and sensitivity (__/___/___)_____

24-hour urine (___/___/___) ECC_____ TP_____

*Stool Examination with occult blood test (___/___/___)_____

*Throat swab culture and sensitivity (___/___/___)_____

*Chest X-ray (___/___/___)_____

*Whole Abdomen US (__/___/___)_____

_____

*ECG (__/___/___) _____

*2D Echo (___/___/___) EF_____%_____

_____

Sputum c/s (___/___/___)_____

Chest CT scan (___/___/___)_____

_____

EGD (___/___/___)_____

Colonoscopy (___/___/___)_____

Aorto-iliac dupplex ultrasound of arteries and veins, when indicated (___/___/___)_____

Carotid doppler, when indicated (___/___/___)_____

Dobutamine Stress Echo, when indicated (___/___/___) _____

_____

Cardiac scintigraphy (___/___/___) _____

Serology: (___/___/___)

*HBs Ag_____ *Anti-HBc _____ *Anti-HBs _____ HBV-DNA _____ *Anti-HCV_____HCV-RNA_____
*HIV/HACT_____ *VDRL _____ *CMV IgG titer_____*EBV_____*PSA (for males > 50 yo)_____

Immunology: *PRA Screen (___/___/___) Class I ____% Class II____%
*PRA Specific if PRA Screen Positive, PRA Specific/PRA Single Antigen Bead
(___/___/___) _____
*Tissue Crossmatch (___/___/___) _____
*Blood Type _____ *Tissue Typing ____A_____,_____B_____,_____DR_____,____ No. of HLA Mismatch _____

Immunization Status ☐ **Hepatitis B (__/__/__)** ☐ **Pneumovax (__/__/__)** ☐ **Flu (__/__/__)**

Clearances **(Indicate the dates and physicians)**

*Pre-transplant Orientation _____ *Ethics Committee, if LNRD _____

_____ _____

*Cardiovascular _____ Pulmonary _____

Infectious _____ Urology/Gyne _____

Dental _____ Others _____

* Mandatory service

Certified correct by Attending Nephrologist or Transplant Surgeon:

_____

Printed name and signature

PhilHealth Accreditation No. | | | | | | | | | | | | |

Date signed: _____

PRE-TRANSPLANT EVALUATION FORM FOR KIDNEY TRANSPLANT DONOR
Attachment to Tranche 1

Please answer all questions completely and accurately. Tick appropriate boxes.

Name (Last, First, Middle)_____ ☐ NBB ☐ Fixed Co-Pay

Age _____ Sex ☐ Male ☐ Female Civil Status: ☐ Single ☐ Married ☐ Widow ☐ Separated

Race _____ Hospital No. _____

Permanent Address _____

_____ Tel. No. _____

Present Address _____

_____ Tel. No. _____

Name and address of a close relative or a friend who can provide information in case the donor has a change in address: _____

_____ Tel. No. _____

Nephrologist _____ Transplant Surgeon _____

Urologist _____

PhilHealth ID No. ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

PRE-KIDNEY DONATION DATA

Name of Recipient (Last, First, MI) _____

Specific relationship to the recipient

☐ Living Related Donor

☐ parent ☐ sibling ☐ child ☐ first cousin ☐ nephew/niece ☐ aunt/uncle

☐ Living Non-related Donor

State relationship _____

Past Medical and Social History

☐ No Disease ☐ HPN ☐ DM ☐ Asthma ☐ Renal Stone

☐ Previous Surgeries _____

☐ Allergies _____

☐ Smoking_____ pack- years

☐ Alcohol Intake _____ drinks/per day x _____ years

☐ Others, specify _____

Family history

☐ HPN ☐ DM ☐ Renal Disease, specify _____

☐ Others, specify_____

PRE-KIDNEY DONATION TESTS *(recent laboratory tests and indicate dates)*

Hematology (___/____/____)

*WBC_____*Hgb_____*Hct_____*Platelet_____*Bleeding Time_____*PT_____*PTT_____

Blood Chemistries (___/___/___)

*Crea _____ BUN_____ *FBS _____ *Chole _____ *Trig _____

*SGPT _____*K _____*Na _____ Ca _____ P _____*Uric Acid _____

Others _____

Urine Examination:

* (___/___/___) Sp.Gr._____ pH____ Protein___ Blood___Sugar ___WBC _____RBC_____

* (___/___/___) 24-hour urine TP _____ or Urine Protein Creatinine ratio _____

* (___/___/___) Urine culture and sensitivity _____

Serology:

*HBs Ag	(___/___/___)	☐ Non-reactive	☐ Reactive
Anti-HBc	(___/___/___)	☐ Non-reactive	☐ Reactive
Anti-HBs	(___/___/___)	☐ Non-reactive	☐ Reactive
*Anti-HCV	(___/___/___)	☐ Non-reactive	☐ Reactive
*HIV/HACT	(___/___/___)	☐ Non-reactive	☐ Reactive
*VDRL/TPPA	(___/___/___)	☐ Non-reactive	☐ Reactive
*CMV IgG	(___/___/___)	☐ Negative	☐ Positive
EBV IgG	(___/___/___)	☐ Negative	☐ Positive
Malarial Smear	(___/___/___)	☐ Negative	☐ Positive

Other tests:

Stool Exam with Occult Blood: (___/___/___) _____

* Chest X-ray (___/___/___) _____

* Whole Abdominal US (___/___/___) _____

_____

* ECG (___/___/___) _____

_____

* Nuclear GFR (___/___/___) _____ml/min Normalized GFR _____ml/min

Right_____ml/min _____%, Left_____ml/min _____%

* CT Renal Angiography (___/___/___) _____

_____

* Blood Type _____ *Tissue Typing_____A_____,_____B_____,_____DR_____,_____

No. of HLA Mismatch _____

CLEARANCES *(Indicate the dates and physicians)*

Cardiovascular (___/___/___) _____

Pulmonary (___/___/___) _____

Infectious (___/___/___) _____

Urology (___/___/___) _____

Gynecologic (___/___/___) _____

Others (___/___/___) _____

☐ *Pre-transplant Orientation (___/___/___) ☐ *Ethics Committee, if LNRD (___/___/___)

* Mandatory service

Certified correct by Attending Nephrologist or Transplant Surgeon:

_____

Printed name and signature

PhilHealth Accreditation No. | | | | | | | | | | | | |

Date signed: _____