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.

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

<table>
<thead>
<tr>
<th>IMMUNOSUPPRESSION OPTIONS (choose 1, 2, 3 or 4 only)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Calcineurin inhibitor + mycophenolate + prednisone with or without induction</td>
<td></td>
</tr>
<tr>
<td>a. cyclosporine + mycophenolate motetil or mycophenolate sodium + prednisone OR</td>
<td></td>
</tr>
<tr>
<td>b. tacrolimus + mycophenolate mofetil or mycophenolate sodium + prednisone</td>
<td></td>
</tr>
<tr>
<td>2. Calcineurin inhibitor + mTOR inhibitor + prednisone with or without induction</td>
<td></td>
</tr>
<tr>
<td>a. Low-dose cyclosporine + sirolimus + prednisone OR</td>
<td></td>
</tr>
<tr>
<td>b. Low-dose cyclosporine + everolimus + prednisone</td>
<td></td>
</tr>
</tbody>
</table>
### IMMUNOSUPPRESSION OPTIONS (choose 1, 2, 3 or 4 only)

<table>
<thead>
<tr>
<th>Status</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Calcineurin inhibitor such as cyclosporine + azathioprine + prednisone with or without induction</td>
<td></td>
</tr>
<tr>
<td>4. Steroid-free for zero HLA-mismatch patient or induction using rabbit antithymocyte globulin</td>
<td></td>
</tr>
</tbody>
</table>

### INDUCTION THERAPIES (choose either 1 or 2)

<table>
<thead>
<tr>
<th>Status</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Interleukin-2-receptor antibody (basiliximab) 20 mg IV for two doses</td>
<td></td>
</tr>
<tr>
<td>2. Lymphocyte depleting agents Rabbit anti-thymocyte globulin 1.0-1.5 mg per kg per day for three doses</td>
<td></td>
</tr>
</tbody>
</table>

### ANTI-REJECTION THERAPY, if indicated

- Methylprednisolone 500 mg IV per day for three days

### OTHERS

- Graft renal biopsy, if indicated

---

Certified correct by:  
(Printed name and signature)  
Attending Nephrologist or Transplant Surgeon:

Conforme by:  
(Printed name and signature)  
Patient/Parent/Guardian:

PhilHealth Accreditation No.  

Date signed (mm/dd/yyyy)  

Date signed (mm/dd/yyyy)
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
□ CAD □ Stroke □ PVD □ Liver Disease □ Lupus Pregnancies
□ 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 is 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 duplex 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: ________________________________

Revised as of October 2015
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. □□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□оро

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 __________________________

Revised as of October 2015

Page 5 of 6 of Annex C1 – KT
### 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* __________
- *Sugar* __________
- *WBC* __________
- *RBC* __________
- *_24-hour urine TP*_ __________
- *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/TTPA* (___/___/___)  □ 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* __________
- *No. of HLA Mismatch* __________
- *Pre-transplant Orientation* (___/___/___)  □ *Ethics Committee, if LNRD* (___/___/___)

### CLEARANCES (Indicate the dates and physicians)

- Cardiovascular (___/___/___)
- Pulmonary (___/___/___)
- Infectious (___/___/___)
- Urology (___/___/___)
- Gynecologic (___/___/___)
- Others (___/___/___)

* Mandatory service

Certified correct by Attending Nephrologist or Transplant Surgeon:

---

Printed name and signature

PhilHealth
Accreditation No.

Date signed: __________