Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

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 MANDATORY AND OTHER SERVICES

Kidney Transplantation

Place a (✓) in the appropriate tick box if the service is done or given

Essential Health Services	
☐ Cardiology clearance for recipient	☐ Cardiology clearance for donor (as needed)
☐ Pre-transplant evaluation/labs (Phases 1, 2, 3 and 4) for donor and recipient candidates	☐ Hemodialysis or peritoneal dialysis during admission for transplantation (as indicated)
☐ Transplantation surgery with living or deceased donor	
☐ Immunosuppressant induction therapy, unless identical twin or zero HLA-antigen mismatch	
☐ Immunologic risk- Negative tissue crossmatch between donor and recipient, single organ transplant, PRA class 1 and 2 negative or PRA<20%; no donor specific antibody	

<table>
<tr><th colspan="2">Essential Health Services</th></tr>
<tr><td>Immunosuppression options:
(Tick any one of the following)
☐ Calcineurin inhibitor + mycophenolate + prednisone with or without induction
a. cyclosporine + mycophenolate mofetil or mycophenolate sodium + prednisone OR
b. tacrolimus + mycophenolate mofetil or mycophenolate sodium + prednisone
☐ Calcineurin inhibitor + mTOR inhibitor + prednisone with or without induction
a. Low-dose cyclosporine + sirolimus + prednisone OR
b. Low-dose cyclosporine + everolimus + prednisone
☐ Calcineurin inhibitor such as cyclosporine + azathioprine + prednisone with or without induction
☐ Steroid-free for zero HLA-mismatch patient or induction using rabbit antithymocyte globulin</td><td rowspan="4"></td></tr>
<tr><td>Induction therapies (choose any of the following):
☐ Interleukin-2-receptor antibody (basiliximab) 20 mg IV for two doses
☐ Lymphocyte depleting agents
Rabbit anti-thymocyte globulin 1.0-1.5 mg per kg per day for three doses</td></tr>
<tr><td>For Living Donor Kidney Transplants only
Type of Donor Nephrectomy:
☐ Laparoscopic
☐ Open</td></tr>
<tr><td>For Deceased Donor Kidney Transplant only
Type of Organ Preservation:
☐ Automated Machine Perfusion
☐ Cold Storage</td></tr>
<tr><td></td><td>Anti-rejection therapy (as indicated)
☐ Methylprednisolone 500 mg IV per day for three days</td></tr>
</table>

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

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PRE-TRANSPLANT EVALUATION FORM FOR KIDNEY TRANSPLANT RECIPIENT
Attachment to the Claim*

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

Name (Last, First, MI) ________________________________

☐ Without co-payment ☐ With co-payment

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 (___/___/___)

*Creatinine _____ *BUN_______ *FBS _______ * Cholesterol _______ *Trig _______

*Uric Acid _______ 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__________________________

* These attachments to Annex H-KT are for the reference of the contracted HF which may be used for policy research. PhilHealth shall require submission of these forms; however, the PhilHealth Benefits Administration Section need not assess the clinical contents thereof during claims evaluation.

*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/Gynecology______________________

Dental ______________________________ Others ________________________________

* Essential Health Services

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 the Claim*

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

Name (Last, First, Middle)________________________________

☐ Without co-payment ☐ With co-payment

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

☐ Maintenance Medications and dose_____________________________________

☐ Others, specify ________________________

Family history

☐ HPN ☐ DM ☐ Renal Disease, specify ___________________

*These attachments to Annex H KT are for the reference of the contracted HF which may be used for policy research. PhilHealth shall require submission of these forms; however, the PhilHealth Benefits Administration Section need not assess the clinical contents thereof during claims evaluation.

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

Hematology (____/_____/_____)

*WBC______*Hgb______*Hct______*Platelet______*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 (____/____/____)

* Essential Health Services

Certified correct by Attending Nephrologist or Transplant Surgeon:

____

Printed name and signature

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

Date signed:

____