Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "C2 – KT"

LABORATORY MONITORING FOR RECIPIENT AND DONOR FORM
End Stage Renal Disease requiring Kidney Transplantation (Low Risk)

Tranche 2

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

Recipient	**Dates Performed** *(Should be completed within two months after discharge)*			
CBC (4x)				
Creatinine (4x)				
FBS (4x)				
Potassium (1x)				
SGPT (1x)				
Lipid profile (1x)				
Therapeutic drug level (2x)				

Donor	*(Should be done within one month after discharge)*
CBC (1x)	
Creatinine (1x)	
Urinalysis (1x)	

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

IMMUNOSUPPRESSIVE MEDICATIONS
End Stage Renal Disease requiring Kidney Transplantation (Low Risk)
Attachment to Tranche 2

Date:

Patient's Name **Age** **Sex**

Date of KT

Present Medications

¨	**cyclosporin** **Brand name:**	**_____ mg in the AM**	**_____ mg in the PM** **25 mg tab** **100 mg tab**
¨	**mycophenolate mofetil** **Brand name:**	**500 mg**	**_____ tabs _____ times a day**
¨	**mycophenolate sodium** **Brand name:**	**360 mg**	**_____ tabs _____ times a day**
¨	**tacrolimus** **Brand name:**	**1 mg**	**_____ tabs _____ times a day**
¨	**everolimus** **Brand name:**	**0.25 mg**	**_____ tabs _____ times a day**
¨	**sirolimus** **Brand name:**	**1 mg**	**_____ tabs _____ times a day**
¨	**prednisone** **Brand name:**	**_____ mg**	**_____ tabs _____ times a day**
¨	**azathioprine** **Brand name:**	**50 mg**	**_____ tabs _____ times a day**

Attending Physician

License No.

* This attachment to Annex C2-KT is for the reference of the contracted *HCP* which may be used for policy research. PhilHealth shall require submission of this form; however, the PhilHealth Benefits Administration Section need not assess the clinical contents thereof during claims evaluation.