Case No. _____

Annex "C1 – KT"

HEALTH CARE PROVIDER (HCP)		
ADDRESS OF HCP		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	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, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

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

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

MANDATORY SERVICES	OTHER SERVICES as needed or as indicated
☐ Cardiology clearance for recipient	☐ Cardiology clearance for donor
☐ Pre-transplant evaluation/labs (Phases 1, 2, 3 and 4) for donor and recipient candidates	☐ Hemodialysis or peritoneal dialysis during admission for transplantation
☐ 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, primary kidney transplant, single organ transplant, PRA class 1 and 2 negative or PRA<20%; no donor specific antibody	

MANDATORY SERVICES	OTHER SERVICES
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	
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	
	Anti-rejection therapy ☐ Methylprednisolone 500 mg IV per day for three days
	☐ Graft renal biopsy

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)

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) _____

☐ 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) _____

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 _____ *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_____

* These attachments to Annex C1-KT are for the reference of the contracted *HCP* 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 _____

* 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)_____

☐ 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

☐ Others, specify _____

Family history

☐ HPN ☐ DM ☐ Renal Disease, specify _____

☐ Others, specify_____

* These attachments to Annex C1-KT are for the reference of the contracted *HCP* 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_____*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: _____