



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](http://www.philhealth.gov.ph)



Case No. \_\_\_\_\_

**Annex "C – MORPH"**

**DISCHARGE CHECKLIST FOR Z MORPH**  
**Fitting of External Lower Limb Prosthesis below the Knee**

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>

Place a check mark (✓) on the appropriate lower limb:

Right lower limb     Left lower limb     Right & left lower limbs

Place a (✓) or NA if not applicable

CRITERIA	Yes
1. External below knee lower limb prosthesis provided is as prescribed with appropriate pressure tolerant and sensitive areas, well-fitting socket, good suspension, aligned shank and stable prosthetic foot while standing and walking	
2. The below knee stump is free of pain, blister, vascular compromise, hypersensitivity after 30 minutes of prosthetic weight bearing while standing and/or walking	
3. Prosthesis user ambulates on even and uneven surfaces within expected gait parameters and steps up and down five (5) steps with or without assistive device	
4. Prosthesis user possesses competent skill and knowledge regarding prosthesis donning, doffing, cleaning, precautions and falling techniques	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Rehabilitation Medicine Specialist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	PhilHealth Accreditation No. <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient/Parent/Guardian
Date signed (mm/dd/yyyy)