

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



Case No.	0
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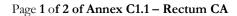
Annex "C1.1- Rectum CA"

CHECKLIST OF MANDATORY AND OTHER SERVICES

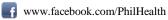
Rectum Cancer Stage I (clinical and pathologic stage)

Single Tranche				
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		ПП	T	
Specify the following:				
Clinical stage prior to initiation of treatment	cT:	N:	M:	
Pathologic stage	pT:	N:	M:	
Place a (✓) if DONE or NA if not applicable in the status column.				
MANDATORY AND OTHER SERVICES Status			Status	
Procedure:				
1. Colonoscopy				
2. Proctoscopy				
3. Histopathology				
4. Surgery (definitive)				
5. Surgery for closure of colostomy/ileostomy, if needed				
Diagnostics:				
6. Pelvic MRI or Endorectal Ultrasound				
7. CT scan of whole abdomen (preferably, triple contrast)				

As of September 2015







9. Carcinoembryonic antigen (CEA), as baseline

8. Fasting blood sugar (FBS)

10. Complete blood count

11. Blood typing 12. Albumin 13. Creatinine

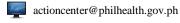




MANDATORY AND OTHE	R SERVICES Status
14. Chest x-ray (PA-L)	
15. Chest CT, as needed	
16. ECG, as needed	
17. CP clearance, as needed	
18. SGPT, as needed	
19. Prothrombin time, as needed	
20. Alkaline phosphatase, as needed	
21. Bilirubin, as needed	
22. CEA for monitoring, as needed	
23. SGPT for monitoring, as needed	
24. Creatinine for monitoring, as needed	
25. 2DEchocardiogram, as needed	
Medicines, as indicated	
1. Antibiotics, specify	
2. Pain relievers, specify	
Others: Blood support, as needed	
Certified correct by:	Certified correct by:
(Printed name and signature)	(Printed name and signature)
Attending Surgeon	Attending Medical Oncologist
PhilHealth Accreditation No.	PhilHealth Accreditation No.
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)
Certified correct by:	Conforme by:
(Printed name and signature)	(Printed name and signature)
Attending Radiation Oncologist	Patient
PhilHealth Accreditation No.	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	







As of September 2015