Case No. _____

Annex "C3.2– Rectum CA"

CHECKLIST OF MANDATORY AND OTHER SERVICES
Rectum cancer pre-operative clinical stage I with post-operative pathologic stage II - III

Tranche 3 of 3

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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

Place a (✓) if DONE or NA if not applicable in the status column.

MANDATORY AND OTHER SERVICES	Status
Procedure:	
1. Proctoscopy, as indicated	
2. Surgery for closure of colostomy/ileostomy, if needed	
Diagnostics:	
1. Complete blood count	
2. Creatinine	
3. Chest x-ray, as needed	
4. Chest CT, as needed	
5. ECG, as needed	
6. Prothrombin time, as needed	
7. Alkaline phosphatase, as needed	
8. Bilirubin, as needed	
9. CEA for monitoring, as needed	
10. SGPT for monitoring, as needed	
11. Creatinine for monitoring, as needed	

MANDATORY AND OTHER SERVICES	Status
Medicines	
A. Any of the following protocols:	
1. Capecitabine-Oxaliplatin (CapeOX)	
2. Fluorouracil-Folinic acid-Oxaliplatin (FOLFOX 4)	
3. Fluorouracil-Folinic acid-Oxaliplatin (mFOLFOX 6)	
B. Antiemetics, specify (as indicated)	
C. Antibiotics, specify (as indicated)	
D. Pain relievers, specify (as indicated)	
Others: Blood support, as needed	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) 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) Attending Radiation Oncologist	(Printed name and signature) Patient
PhilHealth Accreditation No. – –	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	