Annex H.2: Checklist of Essential Health Services for Closure of Ventricular Septal Defect (VSD) With or Without Associated Special Conditions

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH FACILITY (HF)		
SADDRESS OF HF		
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 ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

Checklist of Essential Services for VSD with or without Associated Special Conditions

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

Essential Health Services (As necessary)	
1. Laboratory / Diagnostic Tests	☐ CBC
	☐ Blood typing
	☐ Prothrombin time
	☐ Activated partial thromboplastin time (APTT)
	Serum electrolytes
	☐ Sodium
	☐ Potassium
	☐ Ionized calcium
	☐ Magnesium
	☐ BUN
	☐ Creatinine
	☐ Albumin
	☐ Chest X-ray (PA lateral, portable)
	☐ 12 lead ECG
	☐ Serum lactate
	☐ Arterial blood gas (ABG)
	☐ CBG monitoring
	☐ 2D echo with Doppler (thoracic)
	☐ Transesophageal echocardiogram
2. Drugs/ Medicines	☐ Propranolol
	☐ Furosemide (IV, oral)
	☐ ACE inhibitor Specify: _____

Essential Health Services (As necessary)	
Drugs/ medicines (Cont'd)	☐ Spironolactone
	☐ Digoxin
	☐ Nicardipine
	☐ Sodium bicarbonate
	☐ Sedation/ pain medications: Specify:_____
	☐ Povidone iodine
	☐ Antimicrobials: Specify: _____
	☐ Omeprazole
	☐ Pulmonary medications: Specify:_____
	☐ Hydrocortisone
	☐ Hemodynamic support: Specify: _____
	☐ Intravenous fluids electrolytes: Specify: _____
	☐ Dextrose
	☐ Normal Saline Solution (NSS)
	☐ Sterile water for injections
3. Ancillary services	☐ Dietary (caloric requirement)
	Pulmonary services:
	☐ Incentive spirometry
	☐ Mechanical ventilator use
4. Blood bank services	☐ Antibody screening test (patient)
	Hepatitis screening
	☐ Anti-HCV
	☐ HBsAG
	☐ Cross matching
	☐ HIV screening
	☐ Blood donor antibody screening test (per component)
	☐ Drug assay (blood donor)
5. Procedures	☐ VSD closure (inclusive of perfusion – heart lung machine)
	☐ Anesthetics Specify: _____

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B. MEMBER	☐ Same as patient (Answer the following only if the patient is a dependent) 1. Last Name, First Name, Suffix, Middle Name	
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Certified correct by:	Certified correct by:
(Printed name and signature) Pediatric Cardiovascular Surgeon	(Printed name and signature) Pediatric Anesthesiologist
PhilHealth Accreditation No. ☐☐☐☐–☐☐☐☐☐☐–☐	PhilHealth Accreditation No. ☐☐☐☐–☐☐☐☐☐☐–☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Pediatric Cardiologist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐–☐☐☐☐☐☐–☐	PhilHealth Accreditation No. ☐☐☐☐–☐☐☐☐☐☐–☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Documents received by:	Conforme by:
(Printed name and signature) Z Benefits Coordinator	(Printed name and signature) Parent/Guardian
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)