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. _____

Annex "C – Preterm and Small Baby"

CHECKLIST OF MANDATORY AND OTHER SERVICES
Preterm and Small Baby

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

MANDATORY AND OTHER SERVICES	Status
A. Management	
1. Essential intrapartum and newborn care (EINC)	
2. Thermoregulation	
3. Newborn resuscitation, as needed	
4. Intensive care, as needed	
5. Surfactant therapy, as needed	
6. Ventilatory support, as needed ☐ Mechanical ventilation ☐ Continuous positive airway pressure (CPAP)	
7. Oxygen support, as needed	
8. Management of infection: Empirical antibiotics / antibiotics for sepsis, as needed	
9. Management of anemia, as needed	
10. Management of apnea, as needed	
11. Management of intraventricular hemorrhage; screening for intraventricular hemorrhage (IVH), as needed	
12. Management of jaundice, as needed	
13. Breast feeding/breast milk feeding and counseling, as needed	
14. Kangaroo care, as needed	

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

MANDATORY AND OTHER SERVICES	Status
B. Diagnostics	
1. Complete blood count (CBC)	
2. Blood typing	
3. Bedside glucose test	
4. Blood culture	
5. Serum sodium, potassium, calcium, as needed	
6. Creatinine, as needed	
7. Chest X-ray (antero-posterior/antero-posterior & lateral) (AP/APL)/ 'babygram', as needed	
8. Cranial ultrasound, as needed	
9. Total serum bilirubin, as needed	
10. Blood gas determination, as needed	
11. Cross-matching of blood type, as needed	
12. Prothrombin time, as needed	
13. Cerebrospinal fluid (CSF) determination for protein, glucose, cell count, as needed	
14. CSF culture, as needed	
15. 2-D echocardiography, as needed	
C. Procedures	
1. Peripheral IV insertion	
2. Endotracheal intubation, as needed	
3. Surfactant administration, as needed	
4. Phototherapy, as needed	
5. Umbilical venous cannulation, as needed	
6. Umbilical artery cannulation, as needed	
7. Blood transfusion (e.g. packed RBC), as needed	
8. Double volume exchange transfusion (whole blood), as needed	
9. Thoracostomy tube insertion, as needed	
10. Thoracentesis (chest needling), as needed	
11. Insertion of central line, as needed	
D. Medicines	
1. Eye ointment (erythromycin or tetracycline)	
2. Vitamin K	
3. IV fluid: D_5Water, D_5 0.9 NaCl, D_{10}Water, D_5LR or D_{50} as needed	

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

MANDATORY AND OTHER SERVICES	Status
4. IV antibiotics, as needed ☐ ampicillin ☐ gentamicin ☐ amikacin ☐ others as determined by the hospital antibiogram specify: _____	
5. Inotropes, as needed ☐ dopamine IV ☐ dobutamine IV ☐ epinephrine IV	
6. Anticoagulant (e.g. heparin), as needed	
7. Surfactant, as needed	
8. 0.9 NaCl IV fluid, as needed	
9. Vitamins (e.g. multivitamin drops PO), as needed	
10. Anti-anemia (ferrous sulfate drops PO), as needed	
11. Dibencozide PO, as needed	
12. Parenteral nutrition (e.g., amino acid crystalline solutions), as needed	
13. Calcium gluconate IV, as needed	
14. Bronchodilator (e.g. aminophylline IV), as needed	
15. Analgesic (e.g. paracetamol PO), as needed	
16. Anticonvulsant (e.g. phenobarbital IV or PO), as needed	
E. Birth dose vaccines, as needed	
1. Bacillus Calmette-Guerin (BCG)	
2. Hepatitis B	
F. Screening, as needed	
1. Newborn hearing screening (oto-acoustic emission, OAE)	
2. Newborn metabolic screening (basic panel)	
3. Screening for retinopathy of prematurity (ROP)	
G. Others, as needed	
1. Pre-discharge counseling	
2. Coordinated referral and transfer to a lower level facility	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Parent/Guardian
PhilHealth Accreditation No.	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	