

## 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



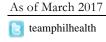
Case No.

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, Suf-	fix)
	,
PHILHEALTH ID NUMBER OF MEMBER	
Place a (✓) in the status column if DONE or NA if not applicable.	
MANDATORY AND OTHER SERVICES	Status

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	
<ul> <li>6. Ventilatory support, as needed</li> <li>☐ Mechanical ventilation</li> <li>☐ Continuous positive airway pressure (CPAP)</li> </ul>	
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
В.	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	7/
	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 <sub>5</sub> Water, D <sub>5</sub> 0.9 NaCl, D <sub>10</sub> Water, D <sub>5</sub> LR or D <sub>50</sub> as needed	

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

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MANDATORY AND OTHE	R 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), a	s needed	
10. Anti-anemia (ferrous sulfate drops PO),	as needed	
11. Dibencozide PO, as needed		/
12. Parenteral nutrition (e.g., amino acid crys	stalline solutions), as needed	//
13. Calcium gluconate IV, as needed		
14. Bronchodilator (e.g. aminophylline IV), a	as needed	
15. Analgesic (e.g. paracetamol PO), as need	ed	
16. Anticonvulsant (e.g. phenobarbital IV or		
E. Birth dose vaccines, as needed		
Bacillus Calmette-Guerin (BCG)		
2. Hepatitis B		
F. Screening, as needed		
	a amission (OAE)	
Newborn hearing screening (oto-acoustic	· ,	
2. Newborn metabolic screening (basic pan	,	
3. Screening for retinopathy of prematurity	(ROP)	
G. Others, as needed		
1. Pre-discharge counseling		
2. Coordinated referral and transfer to a lov	wer level facility	
Certified correct by:	Conforme by:	
(Printed name and signature)	(Printed name and s	ignature)
Attending Physician	Parent/Guard	,
PhilHealth Accreditation No.	Date signed (mm/dd/yyyy)	
Date signed (mm/dd/vvvy)	-	