Annex A.1: Checklist of Eligibility Criteria for Peritoneal Dialysis - Adult

Republic of the Philippines
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Case No._____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	**(Answer only if the patient is a dependent; otherwise, write "same as above")** 1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

PDD Registry No.	
Date of Registration (mm/dd/yyyy)	

Place a (✓) in the box and provide appropriate response/s

History of Previous Dialysis Treatment ☐ Not Applicable	Date of Last Session (mm/dd/yyyy)
With ongoing dialysis session ☐ Yes ☐ No	
If yes, indicate the mode of dialysis: ☐ PD ☐ HD	

Place a (✓) if "Yes"

General Criteria	**YES**
The patient must be at least 19 y/o and above at the time of enrollment to the PD Z package	

Place a (✓) if "Yes"

Continuous Ambulatory Peritoneal Dialysis (CAPD)	**YES**
1. Diagnosed with Chronic Kidney Disease (CKD) Stage 5 requiring renal replacement therapy [does not include those requiring only temporary dialysis for acute kidney injury (e.g. dialysis for leptospirosis)]	
2. Has a permanent peritoneal dialysis catheter properly placed in the abdominal cavity	

Continuous Ambulatory Peritoneal Dialysis (CAPD)	YES
3. Has completed PD initiation in an accredited health facility or accredited PD Z benefits provider	
4. No longer uremic, with stable vital signs	
5. Patients and/or a caregiver have adequate training to perform PD at home using MANUAL exchanges.	
6. Absence of any disease of the abdominal wall, such as injury or surgery, burns, hernia, extensive dermatitis involving the abdomen	
7. Absence of any inflammatory bowel diseases (Crohns' disease, ulcerative colitis or diverticulitis)	
8. Absence of any intra-abdominal tumors or intestinal obstruction	
9. Absence of active serositis	
10. Absence of known or suspected allergy to PD solutions	

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