Annex A.2: Checklist of Eligibility Criteria for Peritoneal Dialysis - Pediatric

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)
Ongoing Dialysis Session ☐ Yes ☐ No	
If yes, indicate the mode of dialysis: ☐ PD ☐ HD	

Place a (✓) if "Yes"

General Criteria	**YES**
1. The patient must be aged 0 to 18 years old and 364 days	
2. Written informed consent from the parents or legal guardian is secured.	

Place a (✓) if "Yes"

Continuous Ambulatory Peritoneal Dialysis (CAPD) / Automated Peritoneal Dialysis (APD)	**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) / Automated Peritoneal Dialysis (APD)	**YES**
3. Has completed PD initiation in an accredited health facility or accredited PD Z benefits provider	
4. Patients and/or a parents or caregiver have adequate training to perform PD at home.	
5. Absence of known or suspected allergy to PD solutions	

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