

Annex I.2A: Checklist of Essential Health Services Using CAPD PD Bags - Pediatric



Republic of the Philippines
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 PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH FACILITY (HF)	DATE OF CONSULTATION (mm/dd/yyyy)
ADDRESS OF HF	
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name SEX <input type="checkbox"/> Male <input type="checkbox"/> Female 2. PhilHealth ID Number <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>
B. MEMBER <input type="checkbox"/> Same as patient (Answer only if the patient is a dependent)	1. Last Name, First Name, Suffix, Middle Name 2. PhilHealth ID Number <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>
Name of the Attending Pediatric Nephrologist	

I. Peritoneal Dialysis Solutions Using CAPD		
A. Number of bags and glucose content using 2L bags (indicate the number of bags on the blank) _____ 1.5% _____ 2.5 % or 2.3 % _____ 4.25%	B. Number of exchanges covered by PhilHealth per day (place a (✓) opposite appropriate answer) _____ 4 _____ 5 _____ 6	C. Calcium content (place a ✓ opposite appropriate answer) _____ Low _____ Regular

II. Supplies and Commodities	Place a (✓) opposite appropriate answer
A. PD Transfer set <input type="checkbox"/> Transfer set given (2 per calendar year, every six months) B. <input type="checkbox"/> PD adapter C. <input type="checkbox"/> PD Clamp D. <input type="checkbox"/> PD drainage bag E. <input type="checkbox"/> Topical antiseptic spray	

Certified correct by: (Printed name and signature) Attending Physician/Pediatric Nephrologist PhilHealth Accreditation No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>	Conformed by: (Printed name and signature) Patient/Parent/Guardian
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

