Annex I.3C: Checklist of Essential Health Services for Laboratory/Diagnostic Tests and Drugs/Medicines For PD Adults and Pediatric Patients

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Case No. _____

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

Place a (✓) opposite appropriate answer

Essential Health Services	
a. Laboratory / Diagnostic Tests (as indicated)	Monthly Adult and pediatric patients ☐ CBC ☐ BUN ☐ Creatinine ☐ Potassium ☐ Calcium ☐ Phosphorus Applicable for pediatric patients ☐ Sodium ☐ Magnesium Quarterly Adult and pediatric patient ☐ Uric Acid ☐ Albumin Quarterly Adult ☐ Fasting blood sugar (FBS) or random blood sugar (RBS) Pediatric patients ☐ 25-OH vitamin D ☐ Intact parathyroid hormone (iPTH) ☐ Alkaline phosphatase ☐ Serum iron ☐ Total iron binding capacity (TIBC)

Essential Health Services	
	□ Ferritin Twice per year Adult □ HBsAg □ Anti-HCV Pediatric patients (every six (6) months) □ Peritoneal Equilibrium Test Adult (as necessary) □ HBA1c
b. Drugs / Medicines (as indicated)	Adult and Pediatric Patients □ Erythropoietin - stimulating agents (e.g. erythropoietin (epoetin) alpha, epoetin beta) Indicate: _____ □ Cholecalciferol 800 IU/cap □ Iron supplements oral 325mg/tab □ IV iron 20mg/ml 5ml amp □ Calcium-based phosphate binders 500mg/tab □ Non-calcium-based phosphate binders (e.g. sevelamer 800mg/tab) Indicate: _____ □ Mupirocin or its equivalent □ Topical antiseptic spray

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