

# Annex N: Certificate of Medical Futility

*As of September 2022*



**Republic of the Philippines**  
**PHILIPPINE HEALTH INSURANCE CORPORATION**  
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Registry No. \_\_\_\_\_

HEALTH FACILITY (HF)		
ADDRESS OF HF		
<b>A. PATIENT</b>	1. Last Name, First Name, Middle Name, Suffix	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>B. MEMBER</b>	<b>(Answer only if the patient is a dependent; otherwise, write, "same as above")</b>	
	1. Last Name, First Name, Middle Name, Suffix	
	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"/>

### CERTIFICATE OF MEDICAL FUTILITY (FOR THE Z BENEFITS FOR PREMATURE OR SMALL BABY)

This is to certify that at the time of discharge, after thorough discussion with the family, the baby's clinical status arising from:

a known lethal condition \_\_\_\_\_,

OR

- progressive deterioration unchanged by maximal interventions
- Full inotropic support
  - High ventilatory support
  - Others: \_\_\_\_\_

was irreversible and would have likely led to death imminently or within days to months.

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Parent/Guardian
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"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	