Revised as of September 2022



Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION



Citystate Centre, 709 Shaw Boulevard, Pasig City Call Center: (02) 8441-7442 Trunkline: (02) 8441-7444 www.philhealth.gov.ph

| Registry No. | |
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KANGAROO CARE PROTOCOL CHECKLIST

(Adopted from various references in a separate list)

| HEALTH FA | CILITY (HF) | | | |
|--|--|--------|--|--|
| ADDRESS OF | F HF | \ | | |
| A. PATIENT | 1. Last Name, First Name, Middle Name, Suffix SEX | | | |
| | 2. PhilHealth ID Number | - 🗌 | | |
| B. MEMBER | . 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 | - 🗆 | | |
| Place a (\checkmark) in the status column if DONE or NA if not applicable. | | | | |
| | | Status | | |
| Kangaroo care are met. | performed as per policy or protocol as soon as eligibility criteria | | | |
| 1. The att | ending physician ordered KMC. | | | |
| 2. Mother protoco | and Father/Guardian were oriented and counseled on KMC | | | |
| to KM0 | for KMC in chart or other pertinent documents (e.g. adaptation C) initiated and completed by attending physician, nurse on duty and social worker. | | | |
| 4. Premature or small baby stays in kangaroo care position with a cap covering the head; the baby is secured in place with an expandable shirt or blouse, preferably for a minimum of two hours per session, (cumulative eight hours/24 hours) | | | | |
| | ed breastfeeding counselling and support, including breastmilk s, progressing to direct breastfeeding | | | |
| 6. Transfe | erred to room or KMC Unit (if applicable) with mother, once | | | |

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| | Status |
|---|--------|
| eligibility criteria for continuous KMC are met | |
| 7. Proceeded with KMC as per policy or protocol until eligible for discharge. | |
| 8. Arrangements for follow-up with other services and outpatient KMC clinic scheduled, as needed. | |

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