Annex C3.1: Rectal Cancer Pre-Operative Clinical Stage I with Post-Operative Pathologic Stage II to III – Post-surgery

Revised as of December 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

UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

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	***(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 ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF MANDATORY AND OTHER SERVICES

***Rectal* cancer pre-operative clinical stage I with post-operative pathologic stage II - III**
Post Surgery

Specify the following:

Clinical stage prior to initiation of treatment	cT:	N:	M:
Pathologic stage	pT:	N:	M:

Place a (✓) in the appropriate tick box if DONE or GIVEN.

MANDATORY SERVICES	OTHER SERVICES as indicated/ as needed
Procedure	
☐ Colonoscopy[a]	☐ Surgery for closure of colostomy/ileostomy[b]
☐ *Biopsy with* histopathology	
☐ Surgery (definitive)	☐ *Proctoscopy*
Diagnostics	
☐ *Chest CT or chest x-ray (PA-L)*[a]	☐ ECG
☐ Pelvic MRI or endorectal ultrasound	☐ CP clearance
☐ CT scan of whole abdomen *preferably with contrast*[a, c]	☐ SGPT
☐ Fasting blood sugar (FBS)	☐ Prothrombin time
☐ Carcinoembryonic antigen (CEA), as baseline	☐ Alkaline phosphatase
☐ Complete blood count	☐ Bilirubin
☐ Blood typing	☐ CEA for monitoring

[a] *should be done within 60 calendar days before the date of submission of the pre-authorization checklist and request to PhilHealth*
[b] *shall be covered under the Z Benefits within two (2) years from the date of surgery; patients may be charged co-payment within the allowable limit as indicated in the contract of the HF*
[c] *PET scan may be accepted in place of CT scan*

MANDATORY SERVICES	OTHER SERVICES as indicated/ as needed
☐ Albumin	☐ SGPT for monitoring
☐ Creatinine	☐ Creatinine for monitoring
Medicines	
	☐ Antiemetics, specify _____
	☐ *Antimicrobials*, specify _____
	☐ Pain relievers, specify _____
	Others: ☐ Blood support

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No. - -	PhilHealth Accreditation No. - -
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Certified correct by:	Conforme by:
(Printed name and signature) Attending Radiation Oncologist	(Printed name and signature) Patient
PhilHealth Accreditation No. - -	Date signed (mm/dd/yyyy)