Annex C3.3: Rectal Cancer Pre-Operative Clinical Stage I with Post-operative Pathologic Stage II to III – After last cycle of Chemotherapy

Revised as of December 2022

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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, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF MANDATORY AND OTHER SERVICES

***Rectal* cancer pre-operative clinical stage I with post-operative pathologic stage II – III**
After last cycle of chemotherapy

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 needed)
Procedures	
	☐ Surgery for closure of colostomy / ileostomy[a]
	☐ Proctoscopy
Diagnostics	
☐ Complete blood count	☐ Chest CT or Chest x-ray (PA-L)
☐ Creatinine	☐ ECG
	☐ Prothrombin time
	☐ Alkaline Phosphatase
	☐ Bilirubin
	☐ CEA, for monitoring
	☐ SGPT, for monitoring
	☐ Creatinine, for monitoring

[a] *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*

MANDATORY SERVICES	*OTHER SERVICES (As needed)*
Medicines	
A. Any of the following protocols:	
☐ Capecitabine-Oxaliplatin (CapeOX)	
☐ Fluorouracil-Folinic acid-Oxaliplatin (FOLFOX 4)	
☐ Fluorouracil-Folinic acid-Oxaliplatin (mFOLFOX 6)	
	☐ 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:	Certified correct by:
(Printed name and signature) Attending Radiation Oncologist	(Printed name and signature) Patient
PhilHealth Accreditation No. ____-_____-_____-_____	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	