Case No. _____

Annex "C1 – TOF"

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

CHECKLIST OF MANDATORY and OTHER SERVICES
TETRALOGY OF FALLOT – ELECTIVE TOF REPAIR

Tranche 1

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

MANDATORY SERVICES	**OTHER SERVICES as needed/ as indicated**
Preoperative laboratory ☐ CBC with platelet with blood typing ☐ Chest X-ray (AP-L) ☐ Na, K, Cl, Ca ☐ Creatinine ☐ Protime ☐ Partial thromboplastin time	
☐ Pre-operative antimicrobial prophylaxis	
☐ Procedure done Repair of Tetralogy of Fallot / *VSD with pulmonic stenosis* • VSD patch closure • With RVOT patch or with infundibulectomy *or pulmonary valvotomy*	
Intra-operative medicines Anesthetic medicines: (any of the following) ☐ sevoflorane ☐ fentanyl ☐ midazolam ☐ atropine ☐ ketamine ☐ esmeron	☐ dexamethasone ☐ calcium gluconate ☐ sodium bicarbonate ☐ potassium chloride ☐ magnesium sulfate ☐ heparin ☐ protamine sulfate

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

MANDATORY SERVICES	OTHER SERVICES as needed/ as indicated
	Inotropes, as indicated: (any of the following) ☐ dopamine ☐ dobutamine ☐ nitroglycerine ☐ epinephrine
	Blood products support ☐ Fresh whole blood (FWB) ☐ Packed red blood cells (pRBC) ☐ Fresh frozen plasma (FFP)
☐ Ventilatory support	
Postoperative Laboratory ☐ CBC with platelet ☐ Chest x-ray (portable) ☐ PT ☐ PTPA ☐ Na, K, Ca ☐ ABG	
(Pre-discharge) laboratory and diagnostics ☐ CBC ☐ Chest X-ray (PAL) ☐ Transthoracic echo prior to discharge (Attach results in the patient's chart)	
Postoperative medications Inotropes: (any of the following) ☐ dopamine ☐ dobutamine ☐ nitroglycerine drip ☐ epinephrine	☐ calcium gluconate
	Pain reliever ☐ tramadol OR ☐ ketorolac OR ☐ other pain reliever: specify _____
	Sedative ☐ midazolam OR ☐ propofol OR ☐ fentanyl ☐ *other sedative: specify* _____
	☐ antimicrobials
	☐ H2 blocker
	☐ oral digoxin
	☐ oral diuretic
	☐ oral vasodilator
	☐ paracetamol or ibuprofen

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

Certified correct by:	Certified correct by:
(Printed name and signature) *Cardiovascular* Surgeon	(Printed name and signature) *Cardiovascular* Anesthesiologist
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 *Pediatric Cardiologist*	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐ – ☐☐☐☐☐☐ –	PhilHealth Accreditation No. ☐☐☐☐ – ☐☐☐☐☐☐ –
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Documents received by:	Conforme by:
(Printed name and signature) Z Benefits Coordinator	(Printed name and signature) Parent/Guardian
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)