Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "C1 – VSD"

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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

VENTRICULAR SEPTAL DEFECT
CHECKLIST OF MANDATORY and OTHER SERVICES

Tranche 1

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

MANDATORY SERVICES	**OTHER SERVICES as needed/ as indicated**
Preoperative Medications, Laboratory and Ancillary procedure	
☐ CBC with platelet with blood typing ☐ Na, K, Cl, Ca ☐ Creatinine ☐ Protime ☐ Partial thromboplastin time ☐ Chest x-ray (AP-L)	*Please indicate if Additional laboratory and or ancillary procedure:* ☐ *2D ECHO CFDS if initial echo was done outside* ☐ *Others (specify):* _____
☐ Pre-operative *antimicrobial* prophylaxis	
Procedure done: VSD Patch closure Intra-operative ***Medications, Laboratory and Ancillary procedure***	
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
☐ Ventilatory support Inotropes: (any of the following) ☐ Dopamine ☐ Dobutamine ☐ Nitroglycerine ☐ Epinephrine	Blood products support ☐ Fresh whole blood (FWB) ☐ Packed red blood cells (pRBC) ☐ Fresh frozen plasma (FFP)
Postoperative Medications, Laboratory and Ancillary procedure	
Respiratory support ☐ *Ventilator* ☐ O2 Mask / Cannula **Laboratory *and Ancillary Procedure*** ☐ CBC with platelet ☐ Chest x-ray (portable) ☐ PT ☐ PTPA ☐ Na, K, Ca ☐ ABG ☐ *2DECHO – CFDS TTE / TEE*	☐ Others (Specify) _____
Medications **Inotropes (any of the following)** ☐ Dopamine ☐ Dobutamine ☐ Nitroglycerine Drip ☐ Epinephrine **Others Specify** _____ **Sedative** ☐ Midazolam OR ☐ Propofol OR ☐ Fentanyl ☐ *other sedative: specify:* _____	**Medications** Paralysis ☐ Rocuronium **Pain reliever** ☐ Tramadol OR ☐ Ketorolac OR ☐ other pain reliever: specify **Other Medications** ☐ Calcium Gluconate ☐ Antimicrobials ☐ H2 Blocker ☐ Oral Digoxin ☐ Oral Diuretic ☐ Oral Vasodilator ☐ Paracetamol Or Ibuprofen ☐ Others (Specify): _____
Pre-discharge Medications, Laboratory and Ancillary procedure	
☐ CBC *and Platelet Count* ☐ Chest x-ray (PAL) ☐ Transthoracic echo prior to discharge (Attach results in the patient's chart)	

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)