



Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION

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Case No. _____

Annex "C1.1 – EMORPH"

**DISCHARGE CHECKLIST FOR EXPANDED ZMORPH
Lower Limb Prosthesis**

Tranche 1

HEALTH CARE INSTITUTION (HCI)	
ADDRESS OF HCI	
PATIENT (Last name, First name, Middle name, Suffix)	
PHILHEALTH ID NUMBER OF PATIENT	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)	
PHILHEALTH ID NUMBER OF MEMBER	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>

Place a (✓) or NA if not applicable

CRITERIA	Yes
1. External lower limb prosthesis provided is as prescribed with appropriate pressure tolerant and sensitive areas, well-fitting socket, good suspension, proper alignment and stable prosthetic foot while standing and walking	
2. The lower limb stump is free of pain, blister, vascular compromise, hypersensitivity after 30 minutes of prosthetic weight bearing while standing and/or walking	
3. Prosthesis user ambulates within expected gait parameters and steps up and down five (5) steps with assistive device	
4. Prosthesis user possesses competent skill and knowledge regarding prosthesis donning, doffing, cleaning, precautions and falling techniques	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Rehabilitation Medicine Specialist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	PhilHealth Accreditation No. <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient/Parent/Guardian
Date signed (mm/dd/yyyy)