

Annex C.1: Checklist of Mandatory and Other Services - Prevention of *Complications of Preterm Delivery*

Revised as of September 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

Registry No. _____

CHECKLIST OF MANDATORY AND OTHER SERVICES

Prevention of *Complications of Preterm Delivery*

HEALTH FACILITY (HF)					
ADDRESS OF HF					
A. PATIENT	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; padding: 5px;">1. Last Name, First Name, Middle Name, Suffix</td> <td style="width: 30%; padding: 5px;">SEX <input type="checkbox"/> Male <input type="checkbox"/> Female</td> </tr> <tr> <td style="padding: 5px;">2. PhilHealth ID Number</td> <td style="padding: 5px;"> <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> </td> </tr> </table>	1. Last Name, First Name, Middle Name, Suffix	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	2. PhilHealth ID Number	<input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/>
1. Last Name, First Name, Middle Name, Suffix	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female				
2. PhilHealth ID Number	<input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/>				
B. MEMBER	<p><i>(Answer only if the patient is a dependent; otherwise, write, "same as above")</i></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; padding: 5px;">1. Last Name, First Name, Middle Name, Suffix</td> </tr> <tr> <td style="padding: 5px;">2. PhilHealth ID Number</td> </tr> </table>	1. Last Name, First Name, Middle Name, Suffix	2. PhilHealth ID Number		
1. Last Name, First Name, Middle Name, Suffix					
2. PhilHealth ID Number					

Place a (✓) in the status column if DONE or NA if not applicable.

Mandatory and other services	Status
A. Antenatal steroid <input type="checkbox"/> dexamethasone IM; OR <input type="checkbox"/> betamethasone IM	
B. Anticonvulsant for severe pre-eclampsia (magnesium sulfate)	
C. Antibiotic for pPROM <input type="checkbox"/> erythromycin ; OR <input type="checkbox"/> ampicillin ; OR <input type="checkbox"/> others: (specify) _____	
D. <i>For women in active labor (cervical dilatation ≥ 4cm), when applicable, assessment of labor using the World Health Organization (WHO) partograph at the referring facility</i> <ul style="list-style-type: none"> • <i>The referring facility must stabilize the woman and initiate assessment of labor, when applicable, using the WHO partograph (for women in active labor) to properly endorse conditions requiring immediate referral to a contracted HF</i> 	

Mandatory and other services	Status
<p><i>for appropriate management and care indicated in PhilHealth Circular No. <u>s22- 2014</u> revised <u>s25-2015</u> (Social Health Insurance Coverage and Benefits For Women About To Give Birth): a. Maternal age below 19 years old at the date of delivery; b. First pregnancy in patients with age 35 years and older at the date of delivery; c. Multiple or multifetal pregnancy e.g. twins and triplets; d. Ovarian abnormality (e.g. ovarian cyst); e. Uterine abnormality (e.g. myoma uteri); f. Placental abnormality (e.g. placenta previa); g. Abnormal fetal presentation (e.g. breech); h. History of 3 (three) or more miscarriages/ abortion; i. History of 1 (one) stillbirth; j. History of major obstetric and/ or gynecologic operation (e.g. cesarean section, uterine myomectomy); k. History of medical conditions (e.g. hypertension, preeclampsia, eclampsia, heart disease, diabetes, thyroid disorder, morbid obesity, moderate to severe asthma, epilepsy, renal disease, bleeding disorder); l. Other risk factors that may arise during present pregnancy (e.g. premature contractions, vaginal bleeding) that warrant referral for further management.</i></p> <ul style="list-style-type: none"> ● <i>The partograph is not required in conditions wherein labor and vaginal delivery are contraindicated and immediate CS is indicated such as: obstructed labor due to severely deformed pelvis; uncontrolled hypertension, severe preeclampsia or eclampsia; profuse antepartum hemorrhage (including placenta previa, uterine rupture, or abruptio placenta); malpresentation (including breech, transverse, oblique, or brow), or fetal compromise (including fetal distress, cord prolapse, or severe intrauterine growth restriction) and others.</i> ● <i>The partograph is also not required when the newborn was delivered outside a health facility and not likely to have been attended by a health care worker.</i> 	
<p>E. Tocolytic agent, as needed</p> <ul style="list-style-type: none"> <input type="checkbox"/> nifedipine <input type="checkbox"/> others: (specify) <p>_____</p>	
<p>F. calcium gluconate IV, as needed</p>	
<p>G. Coordinated referral and transfer from a referring facility</p>	

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
	2. PhilHealth ID Number	<input type="text"/> - <input type="text"/> - <input type="text"/>
B. MEMBER	<i>(Answer only if the patient is a dependent; otherwise, write, "same as above")</i>	
	1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number	<input type="text"/> - <input type="text"/> - <input type="text"/>

Certified correct by:		Conforme by:	
(Printed name and signature) Attending Physician		(Printed name and signature) Parent/Guardian	
PhilHealth Accreditation No.	<input type="text"/> - <input type="text"/> - <input type="text"/>	Date signed (mm/dd/yyyy)	
Date signed (mm/dd/yyyy)			