Prime Care Cebu
IMMEDIATE MEDICAL & DENTAL CARE CENTER

MEDICAL EXAMINATION RECORD

Annual Physical Examination [ ] Pre-Employment [✓]

Last Name: ALBAÑO First Name: LOUELLA M.I: G. Date: 01/23/2020

Address: TALAMBAN, CEBU CITY Age: 27 Y.O. Civil Status: SINGLE Sex: FEMALE

Place of Birth: DAVAO CITY Date of Birth: 10/28/1992 Insurance Provider:

Occupation: CSR Name of Company: IPLOY Tel./ Mobile no. 09323084640

PHYSICAL EXAMINATION

Temp.: 35.8 °C PR: 78 bpm RR: 15 bpm BP: 90/60 mmHg Ht: 143 cm Wt: 44.8 kgs

Visual Acuity: Right Eye: 20/40 Left Eye: 20/30 (with/ without eyeglasses) BMI: 21.9 Underweight: [ ] Overweight: [ ] Normal weight: [✓] Obese: [ ]

MEDICAL HISTORY

Past Medical History: [illegible]

Family History: [illegible]

Previous Hospitalization: [illegible] 2016 [illegible]

Menstrual History: 12 y.o Parity G2P2 LMP: 12-22-17 Contraceptive Use: none Regular: 3-4 days

Review of Systems	Normal	FINDINGS	Review of Systems	Normal	FINDINGS
Head & Scalp	✓		Lungs	✓	
Eyes & Ears	✓		Heart	✓	
Skin / Allergy	✓		Abdomen	✓	
Nose & Sinuses	✓		Genitals	✓	
Mouth / Teeth / Tongue	✓		Extremities		
Neck / Nodes	✓		Reflexes		
Check / Breast			BPE		
			Rectal		

LABORATORY	Normal	FINDINGS	Review of Systems	Normal	FINDINGS
Chest x-Ray	✓		ECG	NA	
CBC	✓		Other Procedures		
Urinalysis	✓				
Fecalysis	NA				
Drug Test					

I certify that I have examined and found the employee to be physically [ ] fit [ ] |Unfit for employment.

Classification:

- [ ] CLASS A Physically fit for all types of work
- [✓] CLASS B Physically fit for all types of work
  Has minor ailment/ defect. Easily curable or offers no handicap to applied.
  - [✓] Needs treatment/ correction EOR
  - [ ] Treatment optional for:
- [ ] CLASS C Physically fit for less strenous type of work. Has minor ailments/defects. Easily curable or offers no handicap to job applied.
  - [ ] Needs treatment/ correction
  - [ ] Treatment optional for:
- [ ] CLASS D Employment at the risk and discretion of the management
- [ ] CLASS E Unfit for employment
- [ ] PENDING For further evaluation of :

Remarks:

Patient's Signature

1-23-20
Date Examined

Mercer Ramos, M.D.
Medical Examiner

License No.

Medgruppe Polyclinics & Diagnostic Center, Inc.

IMMEDIATE MEDICAL AND DENTAL CARE CENTER

2nd Level, APM Centrale, A. Soriano Jr. Ave., N.R.A. Mabolo, Cebu City, 6000 Philippines
Tel Nos. (032) 232-2273 * (032) 266-3245

LABORATORY DEPARTMENT

License TO OPERATE No. : 07-065-17-AS-2

No.: 177566 SO No.: 00787260

Name : ALBAÑO, LOUELLA GODITO Age : 27 yrs. Date: 01/23/2020

Physician : Sex : FEMALE

Company : IPLOY INC., Patient Status:

Charge To: IPLOY INC.,

URINALYSIS

MACROSCOPIC:

Color	Light Yellow
Appearance	Hazy
pH	6.0
Specific Gravity	1.010
Glucose	Negative
Protein	Negative

MICROSCOPIC:

RBC / hpf	0-3
WBC / hpf	1-3
Epith. Cells / hpf	Moderate
Casts	
Mucus Threads	Few
Bacteria	Few
Crystals	
Amorphous (Urates)	Moderate
Amorphous (PO_4)	

MISCELLANEOUS:

Pregnancy Test	N/A

OTHERS:

NOTE:

JEZEBEL C. CAPIROL-CURATIVO
Medical Technologist
RMT

PETER S. AZNAR, M.D., F.P.S.P.
Pathologist
PRC #72410

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LABORATORY DEPARTMENT

License TO OPERATE No. : 07-065-17-AS-2

No.: 179891 SO No.: 00787260

Name: ALBAÑO, LOUELLA GODITO Age: 27 yrs. Date: 01/24/2020

Requested by: Sex: FEMALE

Patient Status: Company: IPLOY INC.,

Charge To: IPLOY INC.,

COMPLETE BLOOD COUNT

				Normal Values
( ) WBC	7,900	/mm^3		4,000-10,000 /mm^3
( ) RBC	4.20	x 10^6 /mm^3		**Adult** F: 4.2 - 5.4 X 10^6/ mm^3 M: 4.7 - 6.10 X 10^6/ mm^3 **Pedia** F: 4.0 - 5.1 X 10^6/ mm^3 M: 4.0 - 5.3 x 10^6/mm^3
( ) Hemoglobin	12.60	gm%		F: 12-15gm% M: 14-17gm%
( ) Hematocrit	38.00	gm%		F: 38-48vol% M: 40-50vol%
Differential Count				
Neutrophils	66	%	*	45-65%
Lymphocytes	28	%		20-35%
Monocytes	4	%		2-9%
Eosinophils	2	%		0-6%
Basophils		%	--	0-2%
Platelet Count	231,000	/mm^3		150,000-450,000 /mm^3
Others				

HBsAg

Anti-HAV IgM

NOTE:

LEDA BETH S. BETAGANSO, RMT
Medical Technologist
Lic. No. 0088325

PETER S. AZNAR, M.D., F.P.S.P.
Pathologist
PRC #72410

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www.Medgruppe.Com
DOH-POEA-MARINA ACCREDITED NO. RLS-584-08-04

Patient Name:	ALBAÑO, LOUELLA GODITO			X-Ray No./Case No.:	**20-01891**
Date of Birth:	10/28/1992	Age: 27	Sex: FEMALE	Date:	JAN 23,2020
Company:	IPLOY INC.,			Examination/Procedure:	CHEST PA
Referred by:	IPLOY INC.,			Service Order No.:	0000787260

X-RAY REPORT

FINDINGS:

Both lungs are clear. The heart is not enlarged. The pulmonary vessels are within normal limits. The trachea is in the midline. Both hemidiaphragms are sharp and distinct. The included bones are unremarkable.

REMARKS:

> NORMAL CHEST

Finding is based on radiographic interpretation. Clinical correlation is suggested.

PATRICK IAN DUMALAGAN
Encoder

KAREN SITACA-DIÑO, MD FPCR PRC#0100318
Radiologist

Date printed: 1/23/2020

VM

Report ID: DTO-R03

QO092892
56

DEPARTMENT OF HEALTH
GRUPPE POLYCLINICS AND DIAGNOSTIC CENTER, INC.
2L APM CENTRALE MALL, SOFIANO AVENUE, MABOLO, CEBU CITY, CEBU
Phone Number 232-2273

DRUG TEST REPORT

CCF No: 202001230050
Name: ALBAÑO, LOUELLA GODITO
Birthdate: 10/28/1992 Age: 27 Gender: F

Transaction Date Time: 1/24/2020 7:17:00AM
Report Date Time: 1/24/2020 4:59:20PM

Test Method TEST KIT

Purpose
Private Employment

Requesting Parties
IPLOY

Result

Drug/Metabolite	*Result*	*Remarks*
METHAMPHETAMINE	NEGATIVE	
TETRAHYDROCANNABINOL	NEGATIVE	

Test Conducted By

66 JEZEBEL C. CAPIROL-CURATIVO
Analyst

Approved By

DR. PETER SAMSON AZNAR 76
Head of Laboratory

Valid Within 12 Month/s from Transaction Date

This is a DOH-DDB IDTOMIS generated report

PRIME CARE CEBU

Prime CARE
CEBU

MEDGRUPPE POLYCLINICS AND DIAGNOSTIC CENTER, INC.
2ND Floor, APM Centrale Mall, Soriano Ave., NRA, Brgy. Mabolo, Cebu City, Philippines 6000
Tel. No. (032) 232-2273 Fax: (032) 234-2273

CUSTODY AND CONTROL FORM
(Form DT-002A - COPY FOR THE DONOR)

SPECIMEN ID NO. LAB ACCESSION NO.

STEP 1 COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

√ A. Client's/Donor's/Subject's Name Lovella G. Albaño √ B. Address: Mabolo, Cebu City √ C. Age: 27yo. √ D. Sex: F
√ E. Employer Name and Address IPlay 9th Flr. Ayala Center Cebu Tower Bohol St. Cebu Business Park, Cebu City
F. Type of Specimen:
/ √ / Urine
/ / Blood
/ / Others(specify) _____
G. Reason for Test :
/ / Pre-employment / √ / Random / / Reasonable Suspicion/Cause
/ / Return to Duty / / Mandatory / / Post Accident
/ / Follow-up / / Others (specify)_____
H. Drug Tests to be Performed: / / THC, COC, PCP, OPI, AMP / √ / THC & MET Only / / Others (specify)_____

STEP 2 COMPLETED BY COLLECTOR

Read specimen temperature within 4 minutes. Is temperature between 32°Cand 38°C? / / Yes / / No	Specimen Collection: / / Observed / / Unobserved Specimen Sampling : / / Single / / Split Specimen Volume: ____ ml. Physical Appearance: Color: _____	Other Observation (Enter Remark)

REMARKS

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initial seal(s). Donor completes STEP 5.

STEP 4: CHAIN OF CUSTODY – INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY

I certify that the specimen given to me by the donor identified in the certification section on Step 5 of this form was collected, sealed and released to the Delivery Service noted in accordance with applicable Department of Health requirements.

X_____ _____AM/PM ▶ SPECIMEN BOTTLE(S) RELEASED TO:
Signature of Collector Time of Collection
_____ ___/___/___ ▶ _____
(PRINT) Collector's Name (first, MI, Last) Date (Mo/Day/Yr) Name of Delivery Service Transferring Specimen to Lab.

RECEIVED AT LAB: ▶ X_____ Signature of Accessioner _____ ___/___/___ ▶ (PRINT) Accessioner's Name (First, MI, Last) Date (Mo/Day/Yr)	STATUS OF THE SPECIMEN (a) Seal Intact / / Yes / / No (b) Transport Device _____ (c) Description _____	SPECIMEN BOTTLE(S) RELEASED TO: _____ Signature & Printed Name of Receiving Person _____ ___/___/___ Print Name (First, MI, Last) Date (Mo/Day/Yr)

STEP 5 COMPLETED BY THE DONOR

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the affixed bottle is correct.

√ _____ √ Lovella G. Albaño √ 01/29/2020
Signature of Donor (PRINT) Donor's Name (First, MI, Last) Date (Mo/Day/Yr)
√ Contact No. 09323084644 √ Date of Birth 10/28/1997
Mo Day Yr

Additional information may be asked from you by the laboratory particularly on drugs and medications.

STEP 6: COMPLETED BY HEAD OF SCREENING LABORATORY

In accordance with applicable Department of Health requirements, my determination/verification is:

/ / NEGATIVE / / POSITIVE / / TEST CANCELLED / / REFUSAL TO TEST BECAUSE:
/ / DILUTED / / ADULTERATED / / SUBSTITUTED
/ / OTHERS (Specify) _____

REMARKS_____

X JEZEBEL C. CAPIROL-CURATIVO, RMT PETER S. AZNAR, M.D., F.P.S.P. ___/___/___
Signature & Name of Analyst (First. MI, Last) Signature & Name of Head of Laboratory (First. MI, Last) Date (Mo/Day/Yr)

STEP 7: COMPLETED BY CONFIRMATORY LABORATORY

In accordance with applicable Department of Health requirements, my determination/verification for the specimen (if tested) is:

/ / CONFIRMED FOR: / / CHALLENGE / / FAILED TO CONFIRM – REASON_____
/ / THC / / MET / / OTHERS _____

X_____ _____ ___/___/___
Signature of Analyst (PRINT) Signature & Name of Head of Laboratory (First. MI, Last) Date (Mo/Day/Yr)

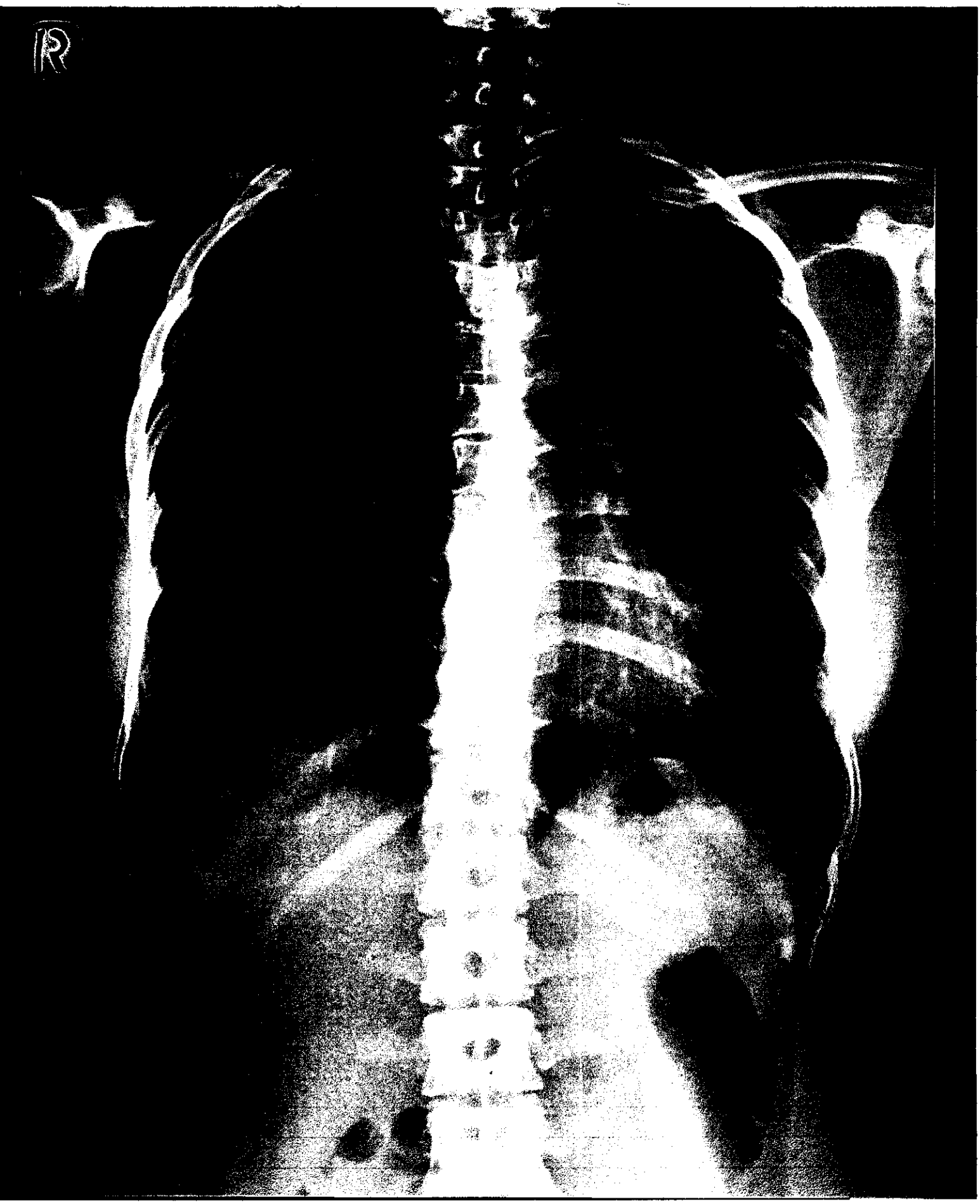
☐ STEP 8 : *TO BE COMPLETED BY NATIONAL REFERENCE LABORATORY (NRL*

In accordance with applicable Department of Health requirements, my determination/verification for the specimen (if tested) is:

/ / RECONFIRMED FOR: / / THC / / MET / / FAILED TO CONFIRM – REASON_____
/ / OTHERS _____

X_____ _____ ___/___/___
Signature of Analyst (PRINT) Signature & Name of Head of Laboratory (First. MI, Last) Date (Mo/Day/Yr)

1. Form DT – 002A - Copy for the Donor
2. Form DT – 002B - . Copy for the Collection Site
3. Form DT – 002C - Copy for the Laboratory
4. Form DT – 002D - . Copy for the Confirmatory Laboratory (For Positive Sample)



atient ID: 20-01891 IPLOY
atient Name: ALBANO,LOUELLA
udy Date: 01/23/2020