Prime Care CFBU
IMMEDIATE MEDICAL & DENTAL CARE C ER

MEDICAL EXAMINATION RECORD

Annual Physical Examination [ ] Pre-Employment [✓]

Last Name AGUILLON First Name DIOSHAN ROYCE M.I P. Date 1/16/20

Address NK PIT TAGBILARAN CEBU CITY Age 21 Civil Status S Sex F

Place of Birth TAGBILARAN CITY Date of Birth 09/08/1998 Insurance Provider

Occupation CSR - Phone Name of Company iPlay, INC. Tel./ Mobile no.

PHYSICAL EXAMINATION

Temp.: 96.6 °C PR: 84 bpm RR: 17 bpm BP: 110/60 mmHg Ht: 152 cm Wt: 69.3 kgs

Visual Acuity: Right Eye: 20/25 Left Eye: 20/25 BMI: 30 Underweight: ☐ Overweight: ☐

(with / without eyeglasses) Normal weight: ☑ Obese: ☑

MEDICAL HISTORY

Past Medical History: (-) any childhood illness

Family History:

Previous Hospitalization: (+) 2013 - UTI

Menstrual History: menarche: 11 y.o Parity GOPO LMP: 12-25-19 7 days irregular Contraceptive Use: NONE

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 Obesity
[ ] 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

1-16-2020
Date Examined

Marina Reyes, M.D.
Medical Examiner
License No. 128113

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

Patient Name:	AGUILLON, DISHAN ROYCE DE PAZ			X-Ray No./Case No.:	**20-01161**
Date of Birth:	9/ 8/1998	Age: 21	Sex: FEMALE	Date:	JAN 16,2020
Company:	IPLOY INC.,			Examination/Procedure:	CHEST PA
Referred by:	IPLOY INC.,			Service Order No.:	0000785940

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: 1/16/2020

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 _____ √ B. Address: NAGKIT HUMDAN CEBU CITY √ C. Age: 21 √ D. Sex: F
√ E. Employer Name and Address IPLOY INC. 9TH FLOOR ACC TOWER CEBU BUSINESS PARK, CEBU CITY
F. Type of Specimen:
/ / Urine
/ / Blood
/ / Others(specify) _____
G. Reason for Test :
/ / Pre-employment / / Return to Duty / / Random / / Mandatory / / Follow-up / / Reasonable Suspicion/Cause / / Post Accident / / 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_____ Signature of Collector
_____ AM/PM Time of Collection ▶
_____ (PRINT) Collector's Name (first, MI, Last)
JAN/16/2020 Date (Mo/Day/Yr) ▶

SPECIMEN BOTTLE(S) RELEASED TO:
_____ Name of Delivery Service Transferring Specimen to Lab.

RECEIVED AT LAB: ▶
X_____ Signature of Accessioner
_____ (PRINT) Accessioner's Name (First, MI, Last)
JAN 16 2020 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.

√ _____ Signature of Donor
√ DIGHAN ROICE P. AGUICON (PRINT) Donor's Name (First, MI, Last)
√ 01 / 16 / 2020 Date (Mo/Day/Yr)
√ Contact No. 09778848288
√ Date of Birth 09 / 05 / 1998 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 Signature & Name of Analyst (First. MI, Last)
PETER S. AZNAR, M.D., F.P.S.P. Signature & Name of Head of Laboratory (First. MI, Last)
JAN 16 2020 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: / / THC / / MET / / OTHERS _____ / / CHALLENGE / / FAILED TO CONFIRM – REASON_____

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

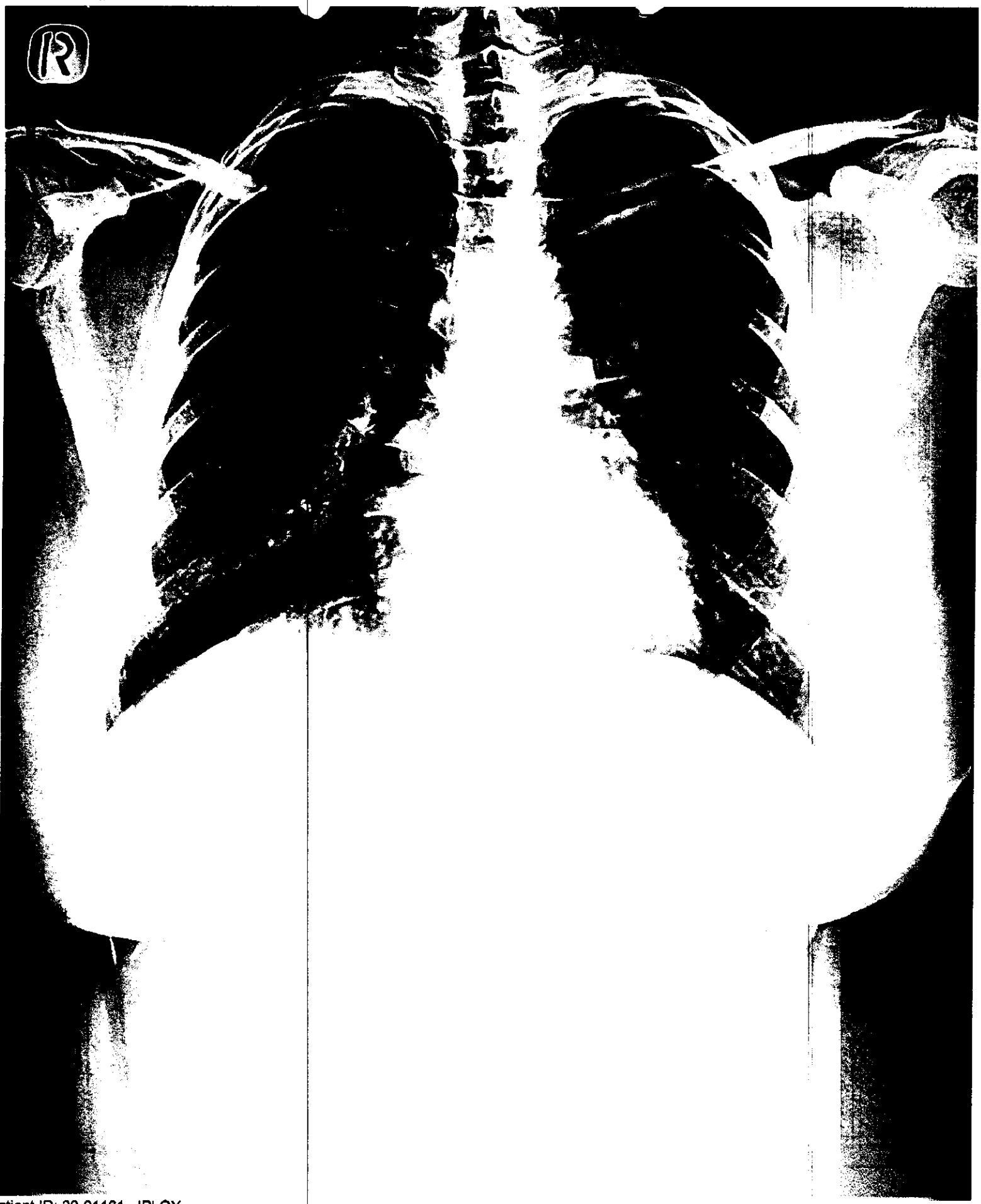
STEP 8 : *TO BE COMPLETED BY NATIONAL REFERENCE LABORATORY (NRL*

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

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

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



Patient ID: 20-01161 IPLOY
Patient Name: AGUILLON,DISHAN ROYCE
Study Date: 01/16/2020