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IMMEDIATE MEDICAL & DENTAL CARE CENTER

MEDICAL EXAMINATION RECORD

Annual Physical Examination [✓] Pre-Employment [ ]

Last Name ABAS First Name TREXSHA M.I T. Date 02/04/2020

Address 151 J.M. BASA ST. CC. Age 25 Civil Status SINGLE Sex FEMALE

Place of Birth CEBU CITY Date of Birth 08/23/1994 Insurance Provider MAXICARE

Occupation CSR Name of Company IPLOY STAFFING SOL. Tel./Mobile no. 09062718192

PHYSICAL EXAMINATION

Temp.: 35.6 °C PR: 89 bpm RR: 19 bpm BP: 120/60 mmHg Ht: 157 cm Wt: 69 kgs

Visual Acuity: Right Eye: 20/25 Left Eye: 20/25 (with / without eyeglasses) BMI: 28.04 Underweight: [ ] Overweight: [✓] Normal weight: [ ] Obese: [ ]

MEDICAL HISTORY

Past Medical History: (-) asthma

Family History: HPN, Diabetes.

Previous Hospitalization: DENGUE, ULCER, Dengue,

Menstrual History: 12 y.o Parity G0P0 LMP: 1-31-2020 7 days, regular Contraceptive Use: None

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

LABORATORY	Normal	FINDINGS	Review of Systems	Normal	FINDINGS
Chest x-Ray	✓		ECG		
CBC	X		Other Procedures		
Urinalysis	✓				
Fecalysis	✓				
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 Obese, HPN
[ ] 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 : N/A

Remarks:

Patient's Signature

02/04/2020
Date Examined

Maureen Ramos, M.D.
Medical Examiner

License No. [illegible]

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) 266-3246

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

No.: 180998 SO No.: 00789582
Name: ABAS, TREXSHA TUICO Age: 25 yrs. Date: 02/05/2020
Requested by: Sex: FEMALE
Patient Status: Company: IPLOY INC.,
Charge To: IPLOY INC.,

COMPLETE BLOOD COUNT

Test	Result	Unit		Normal Values
( ) WBC	10,400	$/mm^3$	*	4,000-10,000 $/mm^3$
( ) RBC	4.84	$x 10^6 /mm^3$		**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	13.70	gm%		F: 12-15gm% M: 14-17gm%
( ) Hematocrit	37.40	gm%	*	F: 38-48vol% M: 40-50vol%
Differential Count				
Neutrophils	66	%	*	45-65%
Lymphocytes	27	%		20-35%
Monocytes	5	%		2-9%
Eosinophils	2	%		0-6%
Basophils		%	–	0-2%
Platelet Count	337,000	$/mm^3$		150,000-450,000 $/mm^3$
Others				

HBsAg
Anti-HAV IgM
NOTE:

CHERRY FAYE D. PEÑA,RMT
Medical Technologist
Lic. No. 0050285

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

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Tel Nos. (032) 232-2273 * (032) 266-3246

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

No.: 179040 SO No.: 00789582
Name : ABAS, TREXSHA TUICO Age : 25 yrs. Date: 02/11/2020
Physician : Sex : FEMALE
Company : IPLOY INC., Patient Status:
Charge To: IPLOY INC.,

URINALYSIS

MACROSCOPIC:

Color	Light Yellow
Appearance	Slightly Hazy
pH	6.5
Specific Gravity	1.010
Glucose	Negative
Protein	Negative

MICROSCOPIC:

RBC / hpf	0-2
WBC / hpf	2-5
Epith. Cells / hpf	Few
Casts	
Mucus Threads	Rare
Bacteria	Rare
Crystals	
Amorphous (Urates)	Rare
Amorphous (PO_4)	

MISCELLANEOUS:

Pregnancy Test	N/A

OTHERS:

NOTE:

CHRISTINE GAYLE P. MAYOL, RMT
Medical Technologist
0081748

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

Medgruppe Polyclinics & Diagnostic Center, Inc.

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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:	ABAS, TREXSHA TUICO	X-Ray No./Case No.:	**20-03192**
Date of Birth:	8/23/1994 Age: 25 Sex: FEMALE	Date:	FEB 4,2020
Company:	IPLOY INC.,	Examination/Procedure:	CHEST PA
Referred by:	IPLOY INC.,	Service Order No.:	0000789582

X-RAY REPORT

FINDINGS:

Both lung fields are essentially clear. The heart is normal in size, shape and position. The trachea is in the midline. Both hemidiaphragm and lateral recesses are sharp and distinct. The osseous thoracic cage reveals no significant bony abnormality.

REMARKS:

NO SIGNIFICANT CARDIOPULMONARY FINDINGS.

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

PATRICK IAN DUMALAGAN
Encoder

FRANCO ALEJANDRO-SORIANO, MD FPCR
Radiologist

Date printed: 2/ 5/2020

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

DRUG TEST REPORT

CCF No: 202002040003
Name: ABAS, TREXSHA TUICO
Birthdate: 08/23/1994 Age: 25 Gender: F

Transaction Date Time: 2/5/2020 7:09:00AM
Report Date Time: 2/5/2020 3:39:48PM

Test Method TEST KIT

Purpose
Private Employment

Requesting Parties
IPLOY

Result

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

Test Conducted By

54 JEZEBEL C. CAPIROL-CURATIVO
Analyst

Approved By

DR. PETER SANSON AZNAR 75
Head of Laboratory

Valid Within 12 Month/s from Transaction Date

This is a DOH-DDB IDTOMIS generated report

PRIME CARE CEBU

Prime CARE
C E B U

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 TREXSHA T. ABAS √ B. Address: 151 J.M. BASA ST, CC √ C. Age: 25 √ D. Sex: F
√ E. Employer Name and Address ____
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°C and 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) __/__/__ 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) __/__/__ 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] Signature of Donor √ TREXSHA T. ABAS (PRINT) Donor's Name (First, MI, Last) √ 02 / 04 / 2020 Date (Mo/Day/Yr)
√ Contact No. 09062718192 √ Date of Birth 08 / 23 / 1994 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)*
__/__/__ *Date (Mo/Day/Yr)*

STEP 7: COMPLETED BY CONFIRMATORY LABORATORY

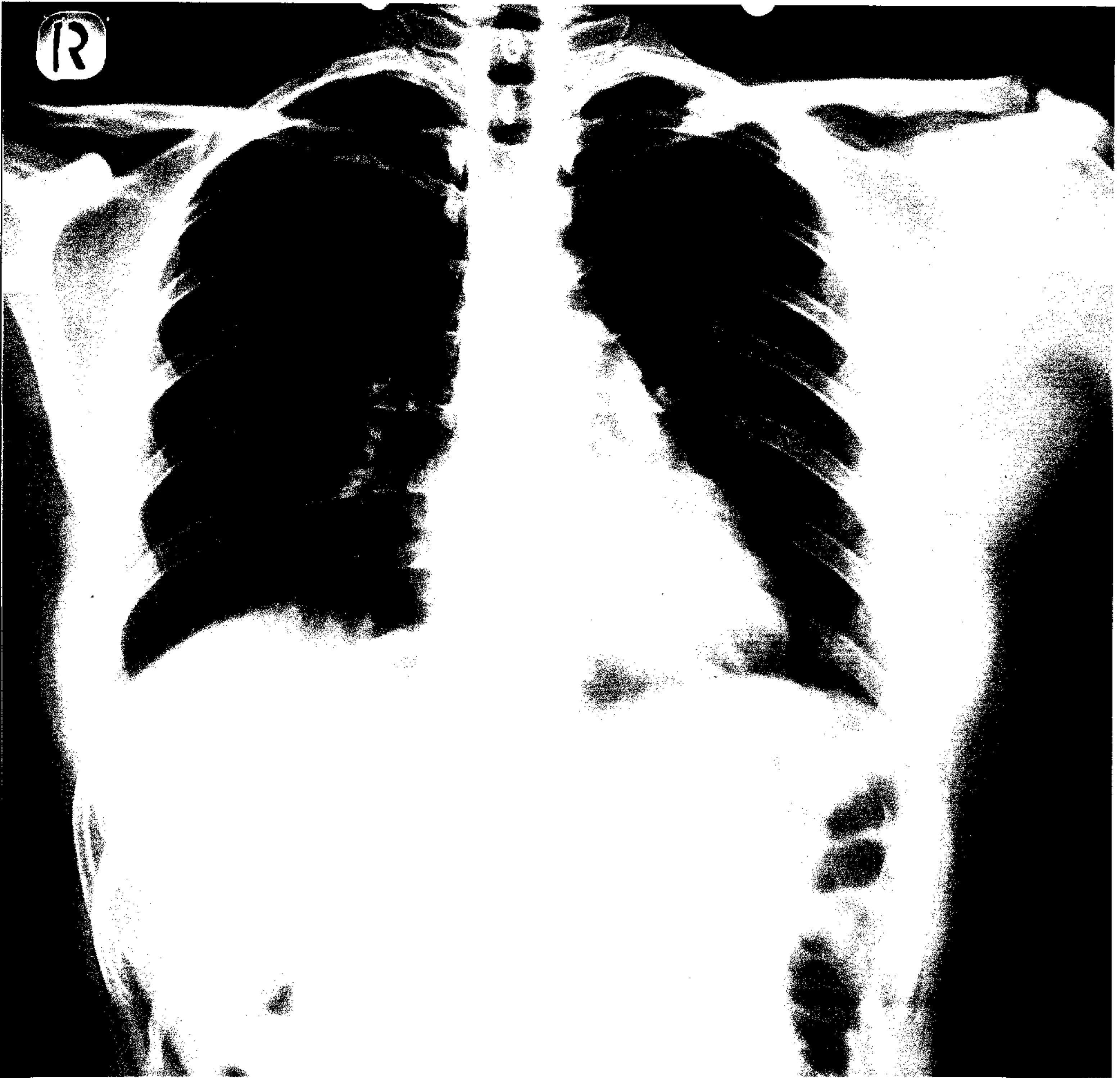
In accordance with applicable Department of Health requirements, my determination/verification for the specimen (if tested) is:
/ / CONFIRMED FOR: / / CHALLENGE / / FAILED TO CONFIRM – REASON ____
/ / THC / / MET / / OTHERS ____
X____ Signature of Analyst ____ (PRINT) Signature & Name of Head of Laboratory (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 Lab (For Positive Sample)



Patient ID: 20-03192 IPLOY
Patient Name: ABAS,TREXSHA
Study Date: 02/04/2020