

analyzed by the doctor. Forms are important in the organization because it is used to collect important details in regards with the patient.

3.1.1 Registration Form for Children Aged 14 years old

Figure 7 show the first page of the registration form for children of 14 years old and below includes the participant number, address, date registered, first name of the patient, family name of the patient, sex, date of birth, age, blood pressure rate, temperature, height, weight, current disease or disorder, hospitalized last year, medication, and kind of treatment received by the patient.

Department of Health
Division Office - Marikina City

HEALTH CENTER ST. EZEKIEL MORENO

Purok St. Ezekiel Moreno, Phase III, Handumanan (Bacolod City)

Tf. 707 58 53

Children until 14 years

1. Date / /
Day Month Year

2. Participant No.

3. Address:

A.1 - NAME: First FAMILY

A.2 - SEX: (1) ☐ Female (2) ☐ Male

A.3 - DATE OF BIRTH / / Age: Years Months Days

A.4 - Weight: kg Height: cm T °C

A.5 - Do you currently have any disease(s) or disorder(s)?

☐ NO

☐ YES

If YES, please specify:

A.6 - Have you been hospitalized in the last year?

☐ NO

☐ YES

If YES, please specify reason(s) and for how long?

1. days

2. days

3. days

A.7 - Are you taking any medication (either prescribed or over the counter)?

☐ NO

☐ YES

If YES, please specify major medications

1.

2.

3.

A.8 - Are you receiving any kind of treatment for your health?

☐ NO

☐ YES

If YES, please specify:

Figure 7. Registration Form for Children (14 years old and below – page 1).

Figure 8 show the second and third page of the registration form for children of 14 years old and below includes the current occupation of the father and mother, past and present health information of the patient, medical diagnosis of the main health condition, relevant information, diagnostic treatment date, and diagnostic treatment description.

A.9 - Additional significant information on your past and present health:

B.4 - CURRENT OCCUPATION of Father

(1) Paid employment [] (7) Retired []
 (2) Self-employed [] (8) Unemployed (health reason) []
 (3) Non-paid work, such as volunteer/charity [] (9) Unemployed (other reason) []
 (4) Student [] (10) Other []
 (5) Keeping house (for others) [] (please specify) _____
 (6) House-maker (Own house) []

CURRENT OCCUPATION of Mother

(1) Paid employment [] (7) Retired []
 (2) Self-employed [] (8) Unemployed (health reason) []
 (3) Non-paid work, such as volunteer/charity [] (9) Unemployed (other reason) []
 (4) Student [] (10) Other []
 (5) Keeping house (for others) [] (please specify) _____
 (6) House-maker (Own house) []

B.5 - MEDICAL DIAGNOSIS of existing Main Health Conditions, if possible give ICD Codes.

1. No Medical Condition exists ICD code: _____
 2. _____ ICD code: _____
 3. _____ ICD code: _____
 4. _____ ICD code: _____
 5. A Health Condition (disease, disorder, injury) exists, however its nature or diagnosis is not known

OTHER CONTEXTUAL INFORMATION

C.1 - Give a thumbnail sketch of the individual and any other relevant information.

HEALTH CENTER ST. EZEKIEL MORENO

Date	Diagnostic - treatment

Figure 8. Registration Form for Children (14 years old and below).

3.1.2 Registration Form for Adults

Figure 9 show the first page of the registration form for adults. It has a similar layout with the registration form for children aged under 14 years old. Except that it some questions regarding to the patient's dominant hand, physical health, mental and emotional health, and significant injuries. In addition, there is that fourth page that has a format same with figure 8 that shows the diagnostics and treatment of the patient.

Health Center ST. EZEKIEL MORENO
Purok St. Ezekiel Moreno, Phase III, Handumanan (Bacolod City)
Tel. 707 58 53

Adult

1. Date: ____/____/____ 2. Participant No. ____

3. Address: _____

A.1 - NAME: First _____ FAMILY _____

A.2 - SEX: (1) ☐ Female (2) ☐ Male

A.3 - DATE OF BIRTH: ____/____/____ Age: ____ Years R: ____

A.4 - Weight: ____ kg Height: ____ cm

A.5 - Dominant Hand: Left ☐ Right ☐ Both hands equally ☐

A.6 - How do you rate your physical health in the past month?
Very good ☐ Good ☐ Moderate ☐ Bad ☐ Very bad ☐

A.7 - How do you rate your mental and emotional health in the past month?
Very good ☐ Good ☐ Moderate ☐ Bad ☐ Very bad ☐

A.8 - Do you currently have any disease(s) or disorder(s)?
☐ NO ☐ YES
If YES, please specify: _____

A.9 - Did you ever have any significant injuries that had an impact on your level of functioning?
☐ NO ☐ YES
If YES, please specify: _____

A.10 - Have you been hospitalized in the last year?
☐ NO ☐ YES
If YES, please specify reason(s) and for how long?
1. _____ days
2. _____ days
3. _____ days

A.11 - Are you taking any medication (either prescribed or over the counter)?
☐ NO ☐ YES
If YES, please specify major medications
1. _____
2. _____

Figure 9. Registration Form (Adults) – page 1.

Figure 10 show the second and third page of the registration form for adults includes the current occupation to whom support the family and the current occupation of the patient, current marital status, years of formal education, cut back health condition and totally unable health condition of the past month, treatment receive, person assisting the patient, assistive device use, alcohol or drug question and smoke question, past and present health information of the patient, medical diagnosis of the main health condition, relevant information, diagnostic treatment date, and diagnostic treatment description.

A.12 - Do you smoke? ☐ NO ☐ YES

A.13 - Do you consume alcohol or drugs? ☐ NO ☐ YES *If YES, please specify average daily quantity:*
Tobacco _____
Alcohol _____
Drugs _____

A.14 - Do you use any assistive devices such as glasses, hearing aid, wheelchair, etc.? ☐ NO ☐ YES *If YES, please specify:* _____

A.15 - Do you have any person assisting you with your self care, shopping or other daily activities? ☐ NO ☐ YES *If YES, please specify person and assistance they provide:* _____

A.16 - Are you receiving any kind of treatment for your health? ☐ NO ☐ YES *If YES, please specify:* _____

A.17 - Additional significant information on your past and present health: _____

A.18 - IN THE PAST MONTH, have you cut back (i.e. reduced) your usual activities or work because of your health condition? (e. disease, injury, emotional reasons or alcohol or drug use) ☐ NO ☐ YES *If YES, how many days?* _____

A.19 - IN THE PAST MONTH, have you been totally unable to carry out your usual activities or work because of your health condition? (e. disease, injury, emotional reasons or alcohol or drug use) ☐ NO ☐ YES *If YES, how many day* _____

B.2 - YEARS OF FORMAL EDUCATION -----

B.3 - CURRENT MARITAL STATUS: (Check only one that is most applicable)

(1) Never married ☐ (4) Divorced ☐
(2) Currently Married ☐ (5) Widowed ☐
(3) Separated ☐ (6) Cohabiting ☐

B.4 - CURRENT OCCUPATION (Select the single best option)

(1) Paid employment ☐ (7) Retired ☐
(2) Self-employed ☐ (8) Unemployed (health reason) ☐
(3) Non-paid work, such as volunteer/charity ☐ (9) Unemployed (other reason) ☐
(4) Student ☐ (10) Other ☐ *Please specify* _____
(5) Keeping house (for others) ☐
(6) House-maker (Own house) ☐

CURRENT OCCUPATION of whom support the Family

(1) Paid employment ☐ (7) Retired ☐
(2) Self-employed ☐ (8) Unemployed (health reason) ☐
(3) Non-paid work, such as volunteer/charity ☐ (9) Unemployed (other reason) ☐
(4) Student ☐ (10) Other ☐ *Please specify* _____
(5) Keeping house (for others) ☐
(6) House-maker (Own house) ☐

B.5 - MEDICAL DIAGNOSIS of existing Main Health Conditions. If possible give ICD Codes.

1. No Medical Condition exists ICD code: _____
2. A Health Condition (disease, disorder, injury) exists, however its nature or diagnosis is not known ICD code: _____
3. A Health Condition (disease, disorder, injury) exists, however its nature or diagnosis is not known ICD code: _____

OTHER CONTEXTUAL INFORMATION

4.1 Give a thumbnail sketch of the individual and any other relevant information.

4.2 Include any Personal Factors as they impact on functioning (e.g. lifestyle, habits, social background, education, life events, race/ethnicity, sexual orientation and assets of the individual).

Figure 10. Registration Form (Adults) – pages 2 and 3.

3.1.3 Prescription Slip

Figure 11 describes the prescription slip that the doctor presents to the patient after the consultation. The prescription slip is used by the doctor to prescribe medicine as well as a referral slip to a specialist if the patient is in need of further treatment.

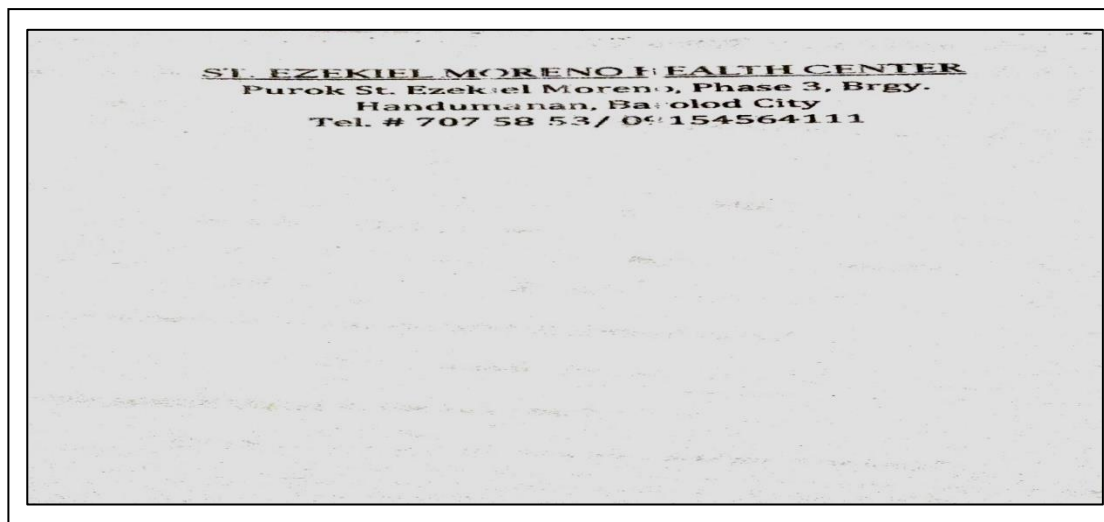


Figure 11. Prescription Slip.

3.1.4 Hematology Report Form

Figure 12 describes the hematology results form. The information is gathered from the patient during the lab study. It includes patient information as well as CBC hematocrit, hemoglobin and the differential count that includes segmenters, stabs, eosinophils, lymphocytes, monocytes, basophils, myelocytes, juveniles, platelet count and blood type. These results will be shown to the doctor if the patient is in need of a referral to a specialist.

ST. EZEKIEL MORENO CLINICAL LABORATORY
Phase III, Brgy Handumanan, Bacolod City

HEMATOLOGY

Name: _____ Date: _____
 Address: _____ Age: _____
 Physician: _____ Gender: _____
 Time Taken: _____

CBC

HEMATOCRIT (M: 0.40 – 0.60) **RESULT:** _____ **WBC** (5-10.0 X 10/L) **RESULT:** _____
 (F: 0.36 – 0.40) **RESULT:** _____ **RBC** (4 – 5 X 10/L) **RESULT:** _____

HEMOGLOBIN (M: 140 – 170) _____
 (F: 120 – 150) _____

DIFFERENTIAL COUNT

Segmenters (0.35 – 0.65) _____
 Stab (0.02 – 0.04) _____
 Eosinophils (0-02) _____
 Lymphocytes (0.20 – 0.35) _____
 Monocytes (0.02 – 0.06) _____
 Basophils (0-0.01) _____
 Myelocytes (0) _____
 Juveniles (0-1) _____

REMARKS: _____

Platelet count (150 – 400 x 10⁹/L) _____
Blood Type _____

SHAIRA L. MALLARI, RMT
Lic. #0077168
Medical Technologist

Lani G. Montes, MD, FPSP
Lic. #77395
Pathologist

Figure 12. Hematology Report Form.

3.1.5 Fecalysis Report Form

Figure 13 describes the fecal reports. The information is gathered from the patient during the lab study. It includes patient information as well as macroscopic section examination which includes color, consistency and helminths. Parasites section includes ascaris, hookworm, trichuris and strongyloides. The chemical test section includes the occult blood while the microscopic examination includes pus cells and RBC. The amoeba section has information regarding to histolytica and coli with cyst and troph. Lastly, information regarding flagellates and its lambia and hominis.


 ST. EZEKIEL MORENO CLINICAL LABORATORY Phase III, Brgy Handumanan, Bacolod City				Time Taken: _____
				Date: _____
<u>FECALYSIS REPORT</u>				
Name: _____	Age: _____		Sex: _____	
Address: _____	Civil Status: _____			
Physician: _____	Test Requested: _____			
<u>MACROSCOPIC EXAMINATION</u>		<u>PARASITES</u>		<u>FLAGELLATES</u>
Color: _____	Ascaris: _____	/LPF	G. lamblia	_____
Consistency: _____	Hookworm: _____	/LPF	T. hominis	_____
Helminths: _____	Trichuris: _____	/LPF		
	Strongyloides: _____	/LPF		
<u>CHEMICAL TEST</u>		<u>AMOEBA</u>		<u>REMARKS:</u> _____ _____ _____ _____ _____
Occult Blood: _____	E. histolytica	/HPF		
	Cyst	/HPF		
	Troph	/HPF		
	E. coli	/HPF		
<u>MICROSCOPIC EXAMINATION</u>				
Pus cells	NONE	Cyst	/HPF	
RBC	NONE	Troph	/HPF	
SHAIRA L. MALLARI, RMT Lic. #0077168 Medical Technologist		Lani G. Montes, MD, FPSP Lic. #77395 Pathologist		

Figure 13. Fecalysis Report Form.

3.1.6 Blood Chemistry

Figure 14 describes the blood chemistry of the patient. It includes patient information and its examination that is shown in both international and conventional units. The information shown about the blood chemistry is as follows: bun, cholesterol, creatinine, fasting blood sugar(FBS), high-density lipoprotein(HDL)-cholesterol, low-density lipoprotein(LDL)-cholesterol, 2 hours post-prandial, ribosome-binding site(RBS), serum glutamic-oxaloacetic transaminase/aspartate aminotransferase(SGOT/AST),

serum glutamic transaminase/alanine aminotransferase(SGPT/ALT), triglyceride and uric acid.

ST. EZEKIEL MORENO CLINICAL LABORATORY
Phase III, Brgy Handumanan, Bacoled City

Last Meal: _____
Time Taken: _____
Date: _____

BLOOD CHEMISTRY I

Name: _____ Age: _____
Address: _____ GENDER: _____
Physician: _____ Test Requested: _____

Examinations:	INTERNATIONAL UNITS	CONVENTIONAL UNIT
	RESULT Reference Values	RESULT Reference Values
BUN		7-18 mg/dl
Cholesterol		150-230 mg/dl
Creatinine		0.5-1.7 mg/dl
FBS		70-100 mg/dl
HDL-Cholesterol		M: 30-60 mg/dl
		F: 40-70 mg/dl
LDL-Cholesterol		60-210 mg/dl
2Hrs Post-Prandial		<120 mg/dl
FBG		mg/dl
SGOT/AST		
SGPT/ALT		
Triglyceride		61.0-243.5 mg/dl
Uric Acid		2.4-6.0 mg/dl
		3.4-7.0 mg/dl

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Lic. #0079651

Medical Technologist

Leni G. Montes, MD, FPSP
Lic. #77395

Pathologist

Figure 14. Blood Chemistry Form.

3.1.7 Urinalysis Report Form

Figure 15 describes the urinalysis report of the patient. It includes patient information and physical properties which includes the color, transparency, pH and specific gravity. The chemical test includes reducing sugar and protein. The cell shows the PUS, RBC, yeast, squamous renal and bacteria. The casts include DESA, course granular, fine granular, PUS, RBC and waxy. The crystals include information about the amorphous urates, amorphous PO₄, uric acid, calcium oxalate, and triple PO₄. There are other information provided like the mucus threads and remarks if the doctor has any comments or suggestions to the patient.

ST. EZEKIEL MORENO CLINICAL LABORATORY Phase III, Brgy Handumanan, Bacolod City			
URINALYSIS REPORT Name: _____ Address: _____ Physician: _____		Time Taken: _____	Date: _____
		Age: _____	Sex: _____
		Civil Status: _____	Test Requested: _____
PHYSICAL PROPERTIES	CELL:		CRYSTALS
Color: _____	PUS _____	/HPF	Amorphous Urates _____
Transparency: _____	RBC _____	/HPF	Amorphous PO ₄ _____
pH: _____	Yeast _____	/HPF	Uric Acid _____
Specific Gravity: _____	Squamous _____	/LPF	Calcium Oxalate _____
	Renal _____	/LPF	Triple PO ₄ _____
	Bacteria _____	/HPF	
CHEMICAL TEST	CASTS		OTHERS:
Reducing Sugar _____	DESA _____	/LPF	Mucus Threads _____
Protein _____	Course Granular _____	/LPF	REMARKS:
	Fine Granular _____	/LPF	_____
	Pus _____	/LPF	_____
	RBC _____	/LPF	_____
	Waxy _____	/LPF	_____
KRISHIEL ANN D. VILLALON, RMT Lic #0079651 Medical Technologist		Leni G. Montes, MD, FPSP Lic. #77395 Pathologist	

Figure 15. Urinalysis Report Form.