

03月02日 5J308 核酸检测必填表格 (共4页)

说明：该表格为必填，请务必提前打印填好，交于核酸检测现场！未提前填好或现场未交表，将被拒绝检测，航司将拒绝您登机！视为客人自愿取消，机票费用不退！

个人信息登记表 (请务必真实填写)

航班日期：03月02日

航班号：5J308

航线：马尼拉-广州

本人中文名字		拼音名字		性别		出生日期	
国籍		民族		婚育状况			
现工作(学习)单位		单位地址					
身份证号码				户籍详址			
护照号码							
家庭住址				联系电话			
本人联系方式	联系电话			电子邮箱			
	通讯地址					邮编	
本人家庭关系人	姓名	关系(父母、子女)	工作单位		联系电话	是否居住在菲律宾 (请标明居住城市)	

同行人员登记	姓名	关系	工作单位	联系电话	菲律宾停留城市	菲律宾停留时长

1、近14天是否接触过可疑病例及发热病人：是 否

2、近14天是否有家人、朋友、同事发热或患肺炎等疾病：是 否

3、近14天您本人是否有如下症状：

发热 咳嗽 咳痰 鼻塞 流涕 咽痛 头痛
 乏力 胸闷 恶心 呕吐 腹泻 腹痛 肌肉酸痛 关节酸痛
 气促呼吸困难 结膜充血

(请在对应的 打√)

本人郑重承诺：如实填写上述内容，自觉履行疫情防控的法律法规义务，承担相应的法律法规责任。

乘客本人承诺

此表内容确系真实、准确、完整，所提供的个人信息、家庭成员情况、同行人员情况等所有信息均没有遗漏、差错，如有隐瞒或不实将由本人承担一切责任。

本人签名：

年 月 日



General Instructions

- 1) The Case Investigation Form is meant to be administered as an Interview by a health care worker or any personnel of the Disease Reporting Unit.
- This is not a Self-Administered Questionnaire.
- 2) Please be advised that Disease Reporting Units are only allowed to obtain **1 copy of accomplished CIF** from a patient.
- 3) Please fill out all blanks and put a check mark on the appropriate box. Never leave an item blank, just write N/A or not applicable. **Items with * are required fields.**
- 4) All dates must be in **MM/DD/YYYY format**.

Disease Reporting Unit*	DRU Region and Province	PhilHealth No.*
Name of Interviewer	Contact Number of Interviewer	Date of Interview (MM/DD/YYYY) *
Name of Informant (If patient unavailable)	Relationship	Contact Number of Informant
Type of Client	<input type="checkbox"/> COVID-19 Case (Suspect, Probable, or Confirmed) <input type="checkbox"/> For RT-PCR Testing (Not a Case of Close Contact)	<input type="checkbox"/> Close Contact <input type="checkbox"/> Others, please specify

1. Testing Category / Subgroup (Check all that apply) Refer to Appendix 1

A B C D E F G H I J

Part 1. Patient Information

2. Patient Profile

Last Name*	First Name (and Suffix)*	Middle Name*
Birthday (MM/DD/YYYY)*	Age*	Sex* <input type="checkbox"/> Male <input type="checkbox"/> Female
Civil Status	Nationality	Occupation

3. Current Address in the Philippines and Contact Information* (Give address of institution if you live in closed settings, see Part 2 #9)

House No./Lot/Bldg.	Street/Purok/Sitio	Barangay	Municipality/City
Province	Home Phone No. (& Area Code)	Cellphone No.	Email Address

4. Current Workplace Address and Contact Information

Lot/Bldg.	Street	Barangay	Municipality/City
Province	Name of Workplace	Phone No./Cellphone No.	Email Address

5. Consultation and Admission Information

Did you have previous COVID-19 related consultation?	<input type="checkbox"/> Yes, Date of First Consult (MM/DD/YYYY)*	<input type="checkbox"/> No	
Name of facility where first consult was done			
Was the case admitted in a health facility?	<input type="checkbox"/> Yes, Date of Admission (MM/DD/YYYY)* <i>Indicate earliest date if admitted in multiple health facilities</i>		<input type="checkbox"/> No
Name of Facility where patient was first admitted			
Region and Province of Facility			

6. Disposition at Time of Report* (Provide name of hospital/isolation/quarantine facility)

<input type="checkbox"/> Admitted in hospital _____	Date and Time admitted in hospital _____
<input type="checkbox"/> Admitted in isolation/quarantine facility _____	Date and Time isolated/quarantined in facility _____
<input type="checkbox"/> In home isolation/quarantine _____	Date and Time isolated/quarantined at home _____
<input type="checkbox"/> Discharged to home If Discharged: Date of Discharge (MM/DD/YYYY)* _____	<input type="checkbox"/> Others: _____

7. Health Status at Consult*

<input type="checkbox"/> Asymptomatic	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Critical
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8. Case Classification* (Refer to Appendix 2)

<input type="checkbox"/> Suspect	<input type="checkbox"/> Probable	<input type="checkbox"/> Confirmed	<input type="checkbox"/> Non-COVID-19 Case
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PART 2: Case Investigation Details

9. Special Population

Health Care Worker*	<input type="checkbox"/> Yes, Name & location of health facility _____	<input type="checkbox"/> No
Returning Overseas Filipino*	<input type="checkbox"/> Yes, Country of origin _____	<input type="checkbox"/> No
Foreign National Traveler*	<input type="checkbox"/> Yes, Country of origin _____	<input type="checkbox"/> No
Locally Stranded Individual/APOR/Traveler*	<input type="checkbox"/> Yes, City, Mun, & Prov of origin _____	<input type="checkbox"/> No
Lives in Closed Settings*	<input type="checkbox"/> Yes, specify Type of Institution (e.g. prisons, residential facilities, retirement communities, care homes, camps etc.) _____ and specify Name of Institution	

10. Permanent Address and Contact Information (If different from current address)

House No./Lot/Bldg.	Street /Purok/Sitio	Barangay	Municipality/City
Province	Home Phone No. (& Area Code)	Cellphone No.	Email Address

11. Address Outside the Philippines and Contact Information (for Overseas Filipino Workers and Individuals with Residence outside PH)

House No./Lot/Bldg.	Street	Municipality/City	Province
Country	Place of Work	Employer's Name	Employer's/Office Contact No.

12. Clinical Information											
Date of Onset of Illness (MM/DD/YYYY)* Signs and Symptoms (Check all that apply if present)			Comorbidities (Check all that apply if present)								
<input type="checkbox"/> Asymptomatic <input type="checkbox"/> Fever _____ °C <input type="checkbox"/> Cough <input type="checkbox"/> General weakness <input type="checkbox"/> Fatigue <input type="checkbox"/> Headache <input type="checkbox"/> Myalgia <input type="checkbox"/> Sore throat <input type="checkbox"/> Coryza		<input type="checkbox"/> Dyspnea <input type="checkbox"/> Anorexia <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Altered Mental Status <input type="checkbox"/> Anosmia (loss of smell) <input type="checkbox"/> Ageusia (loss of taste) <input type="checkbox"/> Others _____		<input type="checkbox"/> None <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Lung Disease							
				<input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Genito-urinary <input type="checkbox"/> Neurological Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Others _____							
Are you pregnant?			<input type="checkbox"/> Yes, LMP _____ <input type="checkbox"/> No								
High-risk pregnancy?			<input type="checkbox"/> Yes <input type="checkbox"/> No								
Were you diagnosed to have Severe Acute Respiratory Illness? (Refer to Appendix 2)			<input type="checkbox"/> Yes <input type="checkbox"/> No								
Chest imaging findings suggestive of COVID-19											
Imaging Done (Check all that apply)		Results									
<input type="checkbox"/> Chest radiography <input type="checkbox"/> Chest CT <input type="checkbox"/> Lung ultrasound <input type="checkbox"/> None		<input type="checkbox"/> Normal <input type="checkbox"/> Pending <table border="0"> <tr> <td><input type="checkbox"/> Hazy opacities, often rounded in morphology, with peripheral and lower lung distribution.</td> </tr> <tr> <td><input type="checkbox"/> Other findings, specify _____</td> </tr> </table> <input type="checkbox"/> Normal <input type="checkbox"/> Pending <table border="0"> <tr> <td><input type="checkbox"/> Multiple bilateral ground glass opacities, often rounded in morphology, with peripheral and lower lung distribution.</td> </tr> <tr> <td><input type="checkbox"/> Other findings, specify _____</td> </tr> </table> <input type="checkbox"/> Normal <input type="checkbox"/> Pending <table border="0"> <tr> <td><input type="checkbox"/> Thickened pleural lines, B lines (multifocal, discrete, or confluent), consolidative patterns with or without air bronchograms.</td> </tr> <tr> <td><input type="checkbox"/> Other findings, specify _____</td> </tr> </table>				<input type="checkbox"/> Hazy opacities, often rounded in morphology, with peripheral and lower lung distribution.	<input type="checkbox"/> Other findings, specify _____	<input type="checkbox"/> Multiple bilateral ground glass opacities, often rounded in morphology, with peripheral and lower lung distribution.	<input type="checkbox"/> Other findings, specify _____	<input type="checkbox"/> Thickened pleural lines, B lines (multifocal, discrete, or confluent), consolidative patterns with or without air bronchograms.	<input type="checkbox"/> Other findings, specify _____
<input type="checkbox"/> Hazy opacities, often rounded in morphology, with peripheral and lower lung distribution.											
<input type="checkbox"/> Other findings, specify _____											
<input type="checkbox"/> Multiple bilateral ground glass opacities, often rounded in morphology, with peripheral and lower lung distribution.											
<input type="checkbox"/> Other findings, specify _____											
<input type="checkbox"/> Thickened pleural lines, B lines (multifocal, discrete, or confluent), consolidative patterns with or without air bronchograms.											
<input type="checkbox"/> Other findings, specify _____											
13. Laboratory Information											
Test Done* (Check all that apply)	Date Collected*	Laboratory	Results*		Date Released						
<input type="checkbox"/> RT-PCR (OPS)			<input type="checkbox"/> Pending	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	<input type="checkbox"/> Equivocal					
<input type="checkbox"/> RT-PCR (NPS)			<input type="checkbox"/> Pending	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	<input type="checkbox"/> Equivocal					
<input type="checkbox"/> RT-PCR (OPS & NPS)			<input type="checkbox"/> Pending	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	<input type="checkbox"/> Equivocal					
<input type="checkbox"/> RT-PCR (specimen type _____)			<input type="checkbox"/> Pending	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	<input type="checkbox"/> Equivocal					
<input type="checkbox"/> Antigen Test			<input type="checkbox"/> Pending	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	<input type="checkbox"/> Equivocal					
<input type="checkbox"/> Antibody Test			<input type="checkbox"/> IgM (+) IgG (-)	<input type="checkbox"/> IgM (+) IgG (+)	<input type="checkbox"/> IgM (-) IgG (+)	<input type="checkbox"/> IgM (-) IgG (-)					
<input type="checkbox"/> Others _____			Specify Result:								
Have you ever tested positive using RT-PCR before?			<input type="checkbox"/> Yes, Date of Specimen Collection (MM/DD/YYYY)* _____		<input type="checkbox"/> No						
If Yes, Laboratory			Number of previous RT-PCR swabs done								
14. Outcome/Condition at Time of Report*											
<input type="checkbox"/> Active (Currently admitted or in isolation/quarantine)			Recovered, Date of Recovery (MM/DD/YYYY)* _____								
<input type="checkbox"/> Died, Date of Death (MM/DD/YYYY)* _____											
Cause of Death* Immediate Cause _____											
Antecedent Cause _____			Underlying Cause _____								
Part 3: Contact Tracing											
15. Exposure History											
History of exposure to known probable and/or confirmed COVID-19 case 14 days before the onset of signs and symptoms? OR If Asymptomatic, 14 days before swabbing or specimen collection?*			<input type="checkbox"/> Yes, Date of LAST Contact (MM/DD/YYYY)* _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown								
Have you been in a place with a known COVID-19 community transmission 14 days before the onset of signs and symptoms? OR If Asymptomatic, 14 days before swabbing or specimen collection?*			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown exposure								
If Yes, specify place (Check all that apply, provide details such as name of establishment, transport service, venue, location etc. and date of visit in MM/DD/YYYY).											
Place Visited	Details	Date of Visit	Place Visited	Details	Date of Visit						
Health Facility			Transportation								
Closed Settings (e.g. Jail)			Workplace								
Market			Local Travel								
Home			Social Gathering								
International Travel			Others								
School											
16. Travel History											
History of travel/visit/work in other countries with a known COVID-19 transmission 14 days before the onset of signs and symptoms			<input type="checkbox"/> Yes, Country of exit _____ <input type="checkbox"/> No								
Airline/Sea vessel	Flight/Vessel Number		Date of Departure (MM/DD/YYYY)	Date of Arrival in PH (MM/DD/YYYY)							
History of travel/visit/work in other local place with a known COVID-19 transmission 14 days before the onset of signs and symptoms			<input type="checkbox"/> Yes, Place of origin _____ <input type="checkbox"/> No								
Airline/Sea vessel/Bus line/Train	Flight/Vessel Number/ Bus No.		Date of Departure (MM/DD/YYYY)	Date of Arrival in the Current City/Mun (MM/DD/YYYY)							
List the names of persons who were with you two days prior to onset of illness until this date and their contact numbers. *If asymptomatic, list the names of persons who were with you on the day you submitted specimen for testing until this date and their contact numbers. (Use additional space below if needed).			Name	Contact No.							

PATIENT DATA SHEET



Hi-Precision
Diagnostics PLUS

ADVANCED LAB SOLUTIONS
by Hi-Precision Diagnostics

Date : _____ Time : _____ AM/PM Thermal Scan temperature : _____ °C

PERSONAL DETAILS

LASTNAME	FIRST NAME	MIDDLE NAME	PHYSICIAN'S NAME [or indicate N/A if none]
BIRTHDATE (MM-DD-YYYY)			TEST REQUEST/S {if applicable}
AGE	SEX AT BIRTH	O Male O Female	
CONTACT NO/S			
RESIDENCE ADDRESS			

HEALTH DECLARATION

In the past 14 Days, did you have any of the following	NO	YES	
1. Symptoms			Date of first day of symptoms: :
A. Fever (> 37.5°C)			-----
B. Cough			-----
C. Colds			-----
D. Shortness of breath			-----
E. Sore throat			-----
F. Influenza-like symptoms (headache, muscle and joint pain, diarrhea, lack of sense of smell or taste)			-----
2. History of intake of antibiotics or medications for cough, colds, fever Past 3 days only]			
3. Travel to a country outside the Philippines			
4. Household member diagnosed with COVID-19			Date of Last exposure:
5. Contact or exposure to a probable or confirmed case.			-----

Definition of contact or exposure (any of the following)

- Direct care for a patient without using proper PPE
- Other situations as indicated by local risk assessments as dictated by the Local Government Unit (LGU)

- Face-to-face contact within 1 meter and for more than 15 minutes
- Direct physical contact

6. History of Covid-19 infection?			Date swabbed: _____
7. History total antibody (+) OR Ig (+) and IgG (-) rapid antibody result			Date tested : _____
8. History of confinement in the hospital ?			Reason : _____ Date of discharge _____

Please note that in compliance with RA 11332 or the Mandatory Reporting of Notifiable Diseases and Health Events of Public Health Concern Act, those who will be classified as possible, suspect and probable COVID cases will be reported to Regional Epidemiology and Surveillance Units (RESU). The same act also requires that the information that you provide regarding your health condition and possible exposure are true.

As a private client, I understand that I must personally claim or access my results online. If I am unable to personally claim my results, I authorize the release of my results via the following delivery modes:

by proxy pick-up, s/he must present an authorization letter with an attached copy of my and his/her valid I.D.

by sending the physical copy to _____

As a **corporate client**, I understand that I must abide by the instructions given to me by my employer/ company/ HMO/ insurance agent/ broker regarding release of results. When required, I also give my consent and allow HPD to post online and/or forward all the results of my medical examination including, but not limited to laboratory and ancillary examinations, to my employer / company / HMO / insurance agent / broker

Hi-Precision Diagnostics respects and puts utmost priority on the confidentiality of your personal information. Please read our Privacy Policy to understand how we protect and use your personal information in accordance with Data Privacy Act of 2012, its Implementing Rules and Regulations, other issuances of the National Privacy Commission and other relevant laws of the Philippines. You may access our Privacy Policy at our branches and through our website at hi-precision.com.ph.

Hi-Precision Diagnostics

By signing this registration form, you confirm that you accept our processing of your information and agree to our Privacy Policy. .

Patient or Legal Guardian's* Signature over Printed Name/ Date Signed

Triage Staff

*Note: If signing as legal guardian for minor or incapacitated patient, please indicate the relationship to patient:



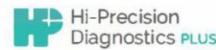
General Instructions

- 1) The Case Investigation Form is meant to be administered as an Interview by a health care worker or any personnel of the Disease Reporting Unit.
- This is not a Self-Administered Questionnaire.
- 2) Please be advised that Disease Reporting Units are only allowed to obtain **1 copy of accomplished CIF** from a patient.
- 3) Please fill out all blanks and put a check mark on the appropriate box. Never leave an item blank, just write N/A or not applicable. **Items with * are required fields.**
- 4) All dates must be in **MM/DD/YYYY** format.

Disease Reporting Unit*		DRU Region and Province	PhilHealth No.*
Name of Interviewer		Contact Number of Interviewer	Date of Interview (MM/DD/YYYY) *
Name of Informant (If patient unavailable)		Relationship	Contact Number of Informant
Type of Client	<input type="checkbox"/> COVID-19 Case (Suspect, Probable, or Confirmed) <input type="checkbox"/> For RT-PCR Testing (Not a Case of Close Contact)		<input type="checkbox"/> Close Contact <input type="checkbox"/> Others, please specify
1. Testing Category / Subgroup (Check all that apply) Refer to Appendix 1			
<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> H <input type="checkbox"/> I <input type="checkbox"/> J			
Part 1. Patient Information 客人信息			
2. Patient Profile 客人资料			
Last Name 姓氏*	First Name (and Suffix) 名字*	Middle Name 中间名* (中国人无)	
Birthday 出生日 (MM 月/DD 日/YYYY 年)*	Age 年龄*	Sex 性别*	<input type="checkbox"/> Male 男 <input type="checkbox"/> Female 女
Civil Status 婚姻状态	Nationality 国籍	Occupation 职业	
3. Current Address in the Philippines and Contact Information* (Give address of institution if you live in closed settings, see Part 2 #9) 现居住菲律宾地址和联系方式 (如您居住在封闭区, 请提供地方政府地址)			
House No./Lot/Bldg. 房号/地段号/栋	Street/Purok/Sitio 街	Barangay 区	Municipality/City 市政当局/市
Province 省	Home Phone No. (& Area Code)	Cellphone No. 手机号码	Email Address 电子邮箱
4. Current Workplace Address and Contact Information 公司地址和联系信息			
Lot/Bldg. 地段号/栋	Street 街	Barangay 区	Municipality/City 市政当局/市
Province 省	Name of Workplace 公司名称	Phone No./Cellphone No. 手机/居家号码	Email Address 电子邮箱
5. Consultation and Admission Information			
Did you have previous COVID-19 related consultation?	<input type="checkbox"/> Yes, Date of First Consult (MM/DD/YYYY)* _____ <input type="checkbox"/> No		
Name of facility where first consult was done			
Was the case admitted in a health facility?	<input type="checkbox"/> Yes, Date of Admission (MM/DD/YYYY)* Indicate earliest date if admitted in multiple health facilities _____ <input type="checkbox"/> No		
Name of Facility where patient was first admitted			
Region and Province of Facility			
6. Disposition at Time of Report* (Provide name of hospital/isolation/quarantine facility)			
<input type="checkbox"/> Admitted in hospital	Date and Time admitted in hospital		
<input type="checkbox"/> Admitted in isolation/quarantine facility	Date and Time isolated/quarantined in facility		
<input type="checkbox"/> In home isolation/quarantine	Date and Time isolated/quarantined at home		
<input type="checkbox"/> Discharged to home If Discharged: Date of Discharge (MM/DD/YYYY)* _____	<input type="checkbox"/> Others: _____		
7. Health Status at Consult*			
<input type="checkbox"/> Asymptomatic	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
<input type="checkbox"/> Critical			
8. Case Classification* (Refer to Appendix 2)			
<input type="checkbox"/> Suspect	<input type="checkbox"/> Probable	<input type="checkbox"/> Confirmed	<input type="checkbox"/> Non-COVID-19 Case
PART 2: Case Investigation Details			
9. Special Population			
Health Care Worker*	<input type="checkbox"/> Yes, Name & location of health facility _____ <input type="checkbox"/> No		
Returning Overseas Filipino*	<input type="checkbox"/> Yes, Country of origin _____ <input type="checkbox"/> No		
Foreign National Traveler*	<input type="checkbox"/> Yes, Country of origin _____ <input type="checkbox"/> No		
Locally Stranded Individual/APOR/Traveler*	<input type="checkbox"/> Yes, City, Mun, & Prov of origin _____ <input type="checkbox"/> No		
Lives in Closed Settings*	<input type="checkbox"/> Yes, specify Type of Institution (e.g. prisons, residential facilities, retirement communities, care homes, camps etc.) _____ and specify Name of Institution _____ <input type="checkbox"/> No		
10. Permanent Address and Contact Information (If different from current address) 永久地址和联系信息 (请填写如不同现居住地址)			
House No./Lot/Bldg. 房号/地段号/栋	Street /Purok/Sitio 街/区域/地点	Barangay 区	Municipality/City 市政当局/市
Province 省	Home Phone No. (& Area Code)	Cellphone No. 手机号码	Email Address 电子邮件
11. Address Outside the Philippines and Contact Information (for Overseas Filipino Workers and Individuals with Residence outside PH) 海外地址和连络信息 (针对在海外菲律宾移工者及海外居住人士)			
House No./Lot/Bldg. 房号/地段号/栋	Street 街	Municipality/City 市政当局/市	Province 省
Country 国家	Place of Work 公司地址	Employer's Name 顾主姓名	Employer's/Office Contact No. 顾主联系电话

12. Clinical Information					
Date of Onset of Illness (MM/DD/YYYY)* Signs and Symptoms (Check all that apply if present)			Comorbidities (Check all that apply if present)		
<input type="checkbox"/> Asymptomatic <input type="checkbox"/> Fever _____ °C <input type="checkbox"/> Cough <input type="checkbox"/> General weakness <input type="checkbox"/> Fatigue <input type="checkbox"/> Headache <input type="checkbox"/> Myalgia <input type="checkbox"/> Sore throat <input type="checkbox"/> Coryza			<input type="checkbox"/> Dyspnea <input type="checkbox"/> Anorexia <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Altered Mental Status <input type="checkbox"/> Anosmia (loss of smell) <input type="checkbox"/> Ageusia (loss of taste) <input type="checkbox"/> Others _____		
			<input type="checkbox"/> None <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Lung Disease		
			<input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Genito-urinary <input type="checkbox"/> Neurological Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Others _____		
			Are you pregnant? _____		
			High-risk pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Were you diagnosed to have Severe Acute Respiratory Illness? (Refer to Appendix 2) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No					
Chest imaging findings suggestive of COVID-19					
Imaging Done (Check all that apply)		Results			
<input type="checkbox"/> Chest radiography <input type="checkbox"/> Chest CT <input type="checkbox"/> Lung ultrasound <input type="checkbox"/> None		<input type="checkbox"/> Normal <input type="checkbox"/> Pending <input type="checkbox"/> Hazy opacities, often rounded in morphology, with peripheral and lower lung distribution. <input type="checkbox"/> Other findings, specify _____			
		<input type="checkbox"/> Normal <input type="checkbox"/> Pending <input type="checkbox"/> Multiple bilateral ground glass opacities, often rounded in morphology, with peripheral and lower lung distribution. <input type="checkbox"/> Other findings, specify _____			
		<input type="checkbox"/> Normal <input type="checkbox"/> Pending <input type="checkbox"/> Thickened pleural lines, B lines (multifocal, discrete, or confluent), consolidative patterns with or without air bronchograms. <input type="checkbox"/> Other findings, specify _____			
13. Laboratory Information					
Test Done* (Check all that apply)	Date Collected*	Laboratory	Results*		Date Released
<input type="checkbox"/> RT-PCR (OPS)			<input type="checkbox"/> Pending <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Equivocal		
<input type="checkbox"/> RT-PCR (NPS)			<input type="checkbox"/> Pending <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Equivocal		
<input type="checkbox"/> RT-PCR (OPS & NPS)			<input type="checkbox"/> Pending <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Equivocal		
<input type="checkbox"/> RT-PCR (specimen type)			<input type="checkbox"/> Pending <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Equivocal		
<input type="checkbox"/> Antigen Test			<input type="checkbox"/> Pending <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Equivocal		
<input type="checkbox"/> Antibody Test			<input type="checkbox"/> IgM (+) IgG (-) <input type="checkbox"/> IgM (+) IgG (+) <input type="checkbox"/> IgM (-) IgG (+) <input type="checkbox"/> IgM (-) IgG (-)		
<input type="checkbox"/> Others			Specify Result:		
Have you ever tested positive using RT-PCR before?		<input type="checkbox"/> Yes, Date of Specimen Collection (MM/DD/YYYY)*		<input type="checkbox"/> No	
If Yes, Laboratory		Number of previous RT-PCR swabs done			
14. Outcome/Condition at Time of Report*					
<input type="checkbox"/> Active (Currently admitted or in isolation/quarantine)		Recovered, Date of Recovery (MM/DD/YYYY)*			
<input type="checkbox"/> Died, Date of Death (MM/DD/YYYY)*					
Cause of Death* Immediate Cause		Underlying Cause			
Part 3: Contact Tracing					
15. Exposure History 接触历史					
History of exposure to known probable and/or confirmed COVID-19 case 14 days before the onset of signs and symptoms?					
OR If Asymptomatic, 14 days before swabbing or specimen collection?*					
您是否有过接触可疑或确诊 COVID-19 患者，并在 14 天前复发任何症状？		<input type="checkbox"/> Yes 有, Date of LAST Contact 最后接触者(MM 月/DD 日/YYYY 年)*			
如无症状，是否有在 14 天内做拭子测试或标本收集？*		<input type="checkbox"/> No 没有 <input type="checkbox"/> Unknown 不确定			
Have you been in a place with a known COVID-19 community transmission 14 days before the onset of signs and symptoms?					
OR If Asymptomatic, 14 days before swabbing or specimen collection?					
过去 14 天内您是否有去过 COVID-19 小区传播？并在 14 天前复发任何症状？		<input type="checkbox"/> Yes 有 <input type="checkbox"/> No 没有 <input type="checkbox"/> Unknown exposure 不确定			
If Yes, specify place (Check all that apply, provide details such as name of establishment, transport service, venue, location etc. and date of visit in MM/DD/YYYY).					
如是，请说明地点(请勾选所有适用的选项，并详细提供相关信息，例如：机构名称、运输服务、会场、地点等)及填写拜访日期(年/月/日)。					
Place Visited 拜访地点	Details 详细说明	Date of Visit 拜访日期	Place Visited 拜访地点	Details 详细说明	Date of Visit 拜访日期
Health Facility 卫生设施			Transportation 交通		
Closed Settings 封闭区 (e.g. Jail) (例：监狱)			Workplace 工作地点		
Market 菜市场			Local Travel 国内旅行		
Home 家			Social Gathering 社交聚会		
International Travel 国外旅行			Others 其他		
School 学校					
16. Travel History 旅行历史					
History of travel/visit/work in other countries with a known COVID-19 transmission 14 days before the onset of signs and symptoms?					
过去是否有去旅行/拜访/工作在其他国家，于得知有 COVID-19 传播并在 14 天前复发任何症状？		<input type="checkbox"/> Yes 有, Country of exit 出境地点 <input type="checkbox"/> No 没有			
Airline/Sea vessel 航班/船班	Flight/Vessel Number 航班号/船班号	Date of Departure (MM/DD/YYYY) 出发日期(月/日/年)		Date of Arrival in PH (MM/DD/YYYY) 抵达菲律宾日(月/日/年)	
History of travel/visit/work in other local place with a known COVID-19 transmission 14 days before the onset of signs and symptoms?					
过去是否有去旅行/拜访/工作在其他国家，于得知有 COVID-19 传播并在 14 天前复发任何症状？		<input type="checkbox"/> Yes 有, Place of origin 起原地点 <input type="checkbox"/> No 没有			
Airline/Sea vessel/Bus line/Train 航班/船班/公交路线/火车	Flight/Vessel Number/ Bus No. 航班号/船班号/公交车号	Date of Departure (MM/DD/YYYY) 出发日期(月/日/年)		Date of Arrival in the Current City/Mun (MM/DD/YYYY) 抵达城市/市政局日期(月/日/年)	
List the names of persons who were with you two days prior to onset of illness until this date and their contact numbers. 请列出发病前两天和您接触的人姓名及联系电话。 *If asymptomatic, list the names of persons who were with you on the day you submitted specimen for testing until this date and their contact numbers. (Use additional space below if needed). *如无症状，请列出当天提交标本报告与您接触人的姓名，并提共日期及联系电话。(如填满，下列空格可填写)		Name 名字		Contact No. 连络电话	

PATIENT DATA SHEET 病患基本資料表



* (根据自己填表时间)

Date 日期: 2020.10.20 Time 時間: 14:00 AM/PM Thermal Scan temperature 體溫: 36.4 °C

PERSONAL DETAILS 個人資料

LASTNAME 姓 ZHANG	FIRST NAME 名字 SAN	MIDDLE NAME 中間名	PHYSICIAN'S NAME 醫師姓名 [or indicate N/A if none 如有請填寫]
BIRTHDATE (MM-DD-YYYY) 生日(月/日/年) 08/30/1990			TEST REQUEST/S (if applicable) 申請檢測(如有請填寫)
AGE 年齡 30	SEX AT BIRTH 出生性別 O <input checked="" type="checkbox"/> Male 男 O Female 女	样本	
CONTACT NO/S 連絡電話 0912-345-6789			
RESIDENCE ADDRESS 居住地址 888 Tony S Arnaiz Ave, Makati, Metro Manila			

HEALTH DECLARATION 健康申報

In the past <u>14</u> Days, did you have any of the following 過去 14 天內您是否有出現以下任何症狀:	NO 無	YES 有	
1. Symptoms 症狀			
A. Fever 發燒(> 37.5°C)	<input checked="" type="checkbox"/>		Date of first day of symptoms: 突發症狀第一天日期: _____
B. Cough 咳嗽			
C. Colds 感冒	<input checked="" type="checkbox"/>		Date of first day of symptoms: 突發症狀第一天日期: _____
D. Shortness of breath 呼吸急促	<input checked="" type="checkbox"/>		
E. Sore throat 喉嚨痛	<input checked="" type="checkbox"/>		
F. Influenza-like symptoms (headache, muscle and joint pain, diarrhea, lack of sense of smell or taste) 類似流感症狀 (頭痛, 肌肉和關節疼痛, 腹瀉, 缺乏嗅覺或味覺)	<input checked="" type="checkbox"/>		
2. History of intake of antibiotics or medications for cough, colds, fever Past 3 days only] 您過去前 3 天是否有服用抗生素或咳嗽、感冒、發燒藥物等?	<input checked="" type="checkbox"/>		
3. Travel to a country outside the Philippines 您是否有前往菲律賓以外的其它國家?	<input checked="" type="checkbox"/>		
4. Household member diagnosed with COVID-19 您家庭成員是否有被確診新冠病毒?	<input checked="" type="checkbox"/>		Date of Last exposure: 最後一次接觸日 _____
5. Contact or exposure to a probable or confirmed case. 您是否有跟疑似者或確診者接觸過?			
<i>Definition of contact or exposure (any of the following) 接觸或暴露定義 (以下任意一項):</i>			
• Face-to-face contact within 1 meter and for more than 15 minutes 有在 1 米以內或面對面接觸超過 15 分鐘			
• Direct physical contact 與確診病例之接觸	• Direct care for a patient without using proper PPE 護理人員在照顧感染患者時，未穿戴防護裝備		
6. History of Covid-19 infection 您過去是否有新冠病史?	<input checked="" type="checkbox"/>		Date swabbed 輕喚檢測日期: _____
7. History total antibody (+) OR Ig (+) and IgG (-) rapid antibody result 您過去是否有測 (+) IgM (+) 及 IgG (-) 快速抗體檢驗?	<input checked="" type="checkbox"/>		Date tested 檢測日期: _____
8. History of confinement in the hospital 您過去是否有住院史?	<input checked="" type="checkbox"/>		Reason 原因: _____ Date of discharge 出院日期: _____

Please note that in compliance with RA 11332 or the Mandatory Reporting of Notifiable Diseases and Health Events of Public Health Concern Act, those who will be classified as possible, suspect and probable COVID cases will be reported to Regional Epidemiology and Surveillance Units (RESU). The same act also requires that the information that you provide regarding your health condition and possible exposure are true.

總請注意，根據 RA 11332 強制性傳染病通報及公共衛生法，被列為疑似病患者，將必須通報給地區流行病學和監視單位 (RESU)。並同一時間提供所有個人相關健康狀況和疑似接觸信息。

As a private client, I understand that I must personally claim or access my results online. If I am unable to personally claim my results, I authorize the release of my results via the following delivery modes: 作為私人客戶，我了解並必須親自領取或線上存取結果。若本人無法親自出面領取時，則授權並通過以下傳遞方式發布個人結果：

□ by proxy pick-up, s/he must present an authorization letter with an attached copy of my and his/her valid ID. 透過委託人領取時，委託他人需遞交授權書，並須附上受權者的身份證副本。

□ by sending the physical copy to 將副本傳送到

As a corporate client, I understand that I must abide by the instructions given to me by my employer/ company/ HMO/ insurance agent/ broker regarding release of results. When required, I also give my consent and allow HPD to post online and/or forward all the results of my medical examination including, but not limited to laboratory and ancillary examinations, to my employer /company / HMO / insurance agent / broker 作為公司的客戶，我們了解並遵守雇主/公司/ HMO/保險代理人/經紀人，發布所有相關的結果。如有必要時，我們也同意並允許 HPD 在線上發布或轉發所有的體檢結果，包括但不限於實驗室和輔助檢查，轉發給雇主/公司/ HMO /保險代理人/經紀人等。

Hi-Precision Diagnostics respects and puts utmost priority on the confidentiality of your personal information. Please read our Privacy Policy to understand how we protect and use your personal information in accordance with Data Privacy Act of 2012, its Implementing Rules and Regulations, other issuances of the National Privacy Commission and other relevant laws of the Philippines. You may access our Privacy Policy at our branches and through our website at hi-precision.com.ph.

Hi-Precision Diagnostics 尊重隱私並嚴格保護個人的相關資訊。請閱讀我們的隱私保護政策，以及了解我們如何將保障個人資訊（根據 2012 年數據隱私保護法），其實施規則和條例，國家隱私委員會其他規定以及菲律賓其他相關法律來保障及使用個人信息。您可以通過我們的隱私政策或查詢我們的網址 hi-precision.com.ph

By signing this registration form, you confirm that you accept our processing of your information and agree to our Privacy Policy. 通過簽署登記表，您確認您閱讀並同意接受我們對信息的處理及隱私政策約束。

ZHANG SAN 2020. 10. 20

Patient or Legal Guardian's* Signature over Printed Name/ Date Signed
病患者或法定監護人簽名/日期

Triage Staff
護理人員簽名

*Note: If signing as legal guardian for minor or incapacitated patient, please indicate the relationship to patient:

"注意：如監護人替為未成年或無行為能力人士簽署，請指出與患者的關係：