

**ACCU-LAB**  
**MEDICAL SYSTEM INC.**

BRGY. VILLARICA BABAK DIST., ISLAND GARDEN CITY OF SAMAL

Cell. No. +63961 022 3315

Email Add: acculab.gotmail@yahoo.com

Name : MUCA, JEDE V.  
Physician :

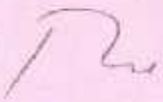
Age : 22.0  
Date : 12/02/22


Sex : Male

**HEMA (RAYTO) L1 - MALE**

RAYTO RT-7600  
AUTO HEMATOLOGY ANALYZER

TEST	RESULT	NORMAL RANGE
White Blood Cells	8.18	5.0 - 10.0 x 10 <sup>9</sup> /L
Lymphocytes	30.1	35.0 - 45.0%
MID cells	5.3	6.0 - 12.0%
Granulocytes	64.6	55.0 - 65.0%
Red Blood Cells	5.77	4.5 - 5.0 10 <sup>12</sup> /L
Hemoglobin	159	140 - 170 g/L
Hematocrit	0.479	0.400 - 0.500 L/L
MCV	83.0	80.0 - 97.0 f/L
MCH	27.6	27.0 - 31.2 pg
MCHC	332	318.0 - 354.0 g/L
RDW	12.6	11.6 - 14.8 %CV
Platelet Count	309	140.0 - 440.0 x 10 <sup>9</sup> /L

  
RENATO R. RAYEL, M.D.  
PATHOLOGIST

  
KATRINA B. CABARSE, RMT  
Medical Technologist

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Name : MUCA, JEDE V.  
Physician :

Age : 22.0  
Date : 12/02/22

Sex : Male

**URINALYSIS - INSIGHT U500**

**INSIGHT U500 URINE ANALYZER**

**PHYSICAL/CHEMICAL EXAMINATION**

Color	: Yellow	Appearance	: Clear
Leukocyte	: negative	Blood	: negative
Nitrite	: negative	Specific Gravity	: 1.020
Urobilinogen	: neg(3.5umol/L)	ketone	: negative
Protein	: negative	Bilirubin	: negative
pH	: 6.0	Glucose	: negative

**MICROSCOPIC EXAMINATION**

Pus Cells	: 0-1/hpf	Epithelial Cells	:
Red Cells	: 0-1/hpf	Renal Cells	:
Bacteria	:	Mucous Threads	:
T.vaginalis	:	Yeast Cells	:


**CASTS**

Hyaline :  
WBC cast :  
RBC cast :  
Fine Granular :  
Coarse Granular :

**CRYSTALS**

Uric Acid :  
Calcium Oxalate :  
Triple Phosphate :  
Amorphous Urates :  
Amorphous Phosphates :

DEC 06 2022

  
**RENATO R. RAYEL, M.D.**  
**PATHOLOGIST**

KATRINA B. CABARSE, RMT  
Lic No. 0000375  
  
**KATRINA B. CABARSE, RMT**  
**Medical Technologist**

**FECALYSIS**

PATIENT: **MUCA, JEDE V.**

AGE: 22

ADDRESS: **TORIL, DAVAO CITY**

GENDER: Male

Date: 12/05/2022

PHYSICIAN:

Control#: 1178556

Color: BROWN  
Consistency: SOFT  
Pus Cells: \_\_\_\_\_  
RBC: \_\_\_\_\_  
Fat Globules: \_\_\_\_\_  
Others: \_\_\_\_\_

Undigested Food: \_\_\_\_\_  
E. Histolytica Cyst: \_\_\_\_\_  
Trophozoite: \_\_\_\_\_  
E. Coll Cyst: \_\_\_\_\_  
Bacteria: \_\_\_\_\_  
Yeast Cells: \_\_\_\_\_

NOTE:

NO OVA FOUND.

DEC 06 2022

  
**DIVINO REY B. LIGUAN, RMT**

PRC No. 0108225

Medical Technologist

  
**DR. FLORANNE MARGARET LAM-VERGARA**

PRC No. 0080008

Pathologist





**NORTH ISLAND**  
Medical Laboratory & Diagnostic Center  
Island Garden City of Samal, Davao del Norte  
(082) 284 7239 to 40 / 0945 659 5468

**RADIOGRAPHIC REPORT**

Name: **MUCA, JEDE**  
Address: **IGACOS**  
Ref. Physician: **DR.**  
Examination: **CHEST PA**

Age: **22**  
Gender: **MALE**  
Date: **AUG. 1, 2022**

**INTERPRETATION**


Lungs are clear.  
The heart is not enlarged, diaphragm and sulci are intact.  
The rest of the included structures are unremarkable.

**IMPRESSION:**

**UNREMARKABLE CHEST FINDINGS**

DEC 06 2022

  
**DARYLLE HANNA T. MILLANES, RRT, RSO**  
RADIOGRAPHER/PRC #:11137

  
**ULAMBAY U. LIDASAN, MD, FPCR, FUSP, FPCT-MRI**  
RADIOLOGIST/PRC #:70193

NOTE: IMAGES ELECTRONICALLY REVIEWED BY THE RADIOLOGIST. THIS RESULT IS BASED ENTIRELY ON THE SONOGRAPHIC IMAGES REVIEWED, WHICH MAY BE LIMITED AT THE TIME OF EXAMINATION. HENCE, IT SHOULD BE CORRELATED WITH CLINICAL FINDINGS AND OTHER ANCILLARY PROCEDURES.

QJ941100  
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DEPARTMENT OF HEALTH  
TORIL DIAGNOSTIC LABORATORY  
DOOR 4 SAAVEDRA BLDG., AGTON ST., TORIL, DAVAO CITY

Phone Number 291-0080

**DRUG TEST REPORT**

CCF No: 202212050008

Name: MUCA, JEDE VILLO

Birthdate: 05/11/2000

Age: 22

Gender: M

Transaction Date Time: 12/5/2022 10:46:00AM

Report Date Time: 12/5/2022 10:56:08AM

Test Method TEST KIT

**Purpose**

Private Employment

**Requesting Parties****Result**

Drug/Metabolite	Result	Remarks
METHAMPHETAMINE	NEGATIVE	
TETRAHYDROCANNABINOL	NEGATIVE	

**Test Conducted By**

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CLARICE BONAYOG LUMANCAS

Analyst

**Approved By**

DR. FLORANNE MARGARET LAM VERGARA45

Head of Laboratory

Valid Within 12 Month/s from Transaction Date

This is a DOH-DDB IDTOMIS generated report

**Toril Diagnostic Laboratory**

DOOR 4 SAAVEDRA BUILDING, AGTON STREET, TORIL, DAVAO CITY  
TEL. NO. (082) 291-0090

**CUSTODY AND CONTROL FORM**  
(Form DT 002C-COPY FOR DONOR)

SPECIMEN ID NUMBER \_\_\_\_\_ LAB ACCESSION Number: \_\_\_\_\_  
STEP 1. COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Client's/Donor's/Subject's Name <u>Edo V. Mura</u>		B. Age <u>2</u>	C. Sex <u>___</u>
D. Type of Specimen <input checked="" type="checkbox"/> Urine <input type="checkbox"/> Blood <input type="checkbox"/> Others (specify) _____	E. Reason for Test <input type="checkbox"/> Pre-employment <input type="checkbox"/> Return to Duty <input type="checkbox"/> Follow-up	<input type="checkbox"/> Random <input type="checkbox"/> Mandatory <input type="checkbox"/> Others (specify) _____	<input type="checkbox"/> Post Accident <input type="checkbox"/> Post Accident <input type="checkbox"/> Others (specify) _____
F. 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? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Specimen Collection: <input checked="" type="checkbox"/> Observed <input type="checkbox"/> Unobserved Specimen Sampling: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Split Specimen Volume: <u>60 ml</u> Physical Appearance: Color: <u>Yellow</u>	Other Observation: (Enter Remark) _____
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REMARKS

STEP 3. COLLECTOR affixes bottle seal(s) to bottle(s). Collector dates seal(s). C O  
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.

Signature of Collector <u>CHERRY D. MANSILAGAN</u> (PRINT) Collector's Name (First, Date(Mo/Day/Yr) <u>12-05-22</u>	Time of Collection <u>12:47</u> <u>AM/PM</u>	(For Courier/Messenger) SPECIMEN BOTTLE(S) RELEASED TO: _____ Name of Delivery Service Transferring Specimen to Lab. _____ (for Confirmatory Laboratory) STATUS OF THE SPECIMEN: SPECIMEN BOTTLE(S) RELEASED TO: a) Seal Intact Yes No b) Transport device _____ Signature Receiving Person _____ c) Description _____ Print Name(First, MI, Last) Date(Mo/Day/Yr)
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STEP 5. COMPLETED BY THE DONOR

I certify that I provided my urine specimen to the collector; that I have not adulterated, substituted and/or diluted 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 (Print) Donor's Name (First, MI, Last) <u>EDO V. MURA</u>	Date(Mo/Day/Yr) _____
Contact No. <u>09770796963</u>	Date of Birth <u>5 11 2010</u> 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 for the specimen is:	
<input type="checkbox"/> NEGATIVE <input type="checkbox"/> POSITIVE <input type="checkbox"/> TEST CANCELLED	<input type="checkbox"/> REFUSAL TO TEST BECAUSE <input type="checkbox"/> DILUTED <input type="checkbox"/> ADULTERATED <input type="checkbox"/> SUBSTITUTED <input type="checkbox"/> OTHERS (specify) _____
Signature of Analyst & Name of the Analyst(First, MI, Last) (PRINT) 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:	
<input type="checkbox"/> CONFIRMED FOR <input type="checkbox"/> CHALLENGE <input type="checkbox"/> FAILED TO CONFIRM-REASON _____	
<input type="checkbox"/> THC <input type="checkbox"/> MET <input type="checkbox"/> OTHERS _____	
Signature of Analyst & Name of the Analyst(First, MI, Last) (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: _____ <input type="checkbox"/> FAILED TO CONFIRM-REASON _____	