

Name: ESTALILLA, FROILAN RAY Company: SONIC SALES Date: 02/22/2020  
Age: 21 Gender: Male Requesting Physician: \_\_\_\_\_ J.O. No.: 0166401

**FECALYSIS**

Color	: Yellowish Brown	Occult Blood	:
Consistency	: Soft		
Microscopic Examination			
Ascaris lumbricoides	: /hpf	Pus Cells	: /hpf
Trichuris trichiura	: /hpf	Red Blood Cells	: /hpf
Enterobius vermicularis	: /hpf	Fat Globules	:
Hookworm Ova	: /hpf	Yeast Cells	:
Giardia lamblia	: /hpf	Undigested Food	:
Blastocystis hominis	: /hpf	Starch Granules	:
Entamoeba histolytica			
a. Cyst	: /hpf		
b. Trophozoite	: /hpf		

**NO OVA OR PARASITE SEEN**

Remarks: \_\_\_\_\_

FEB 26 2020

*Mark D. Abenjar*  
Mark D. Abenjar, RMT  
PRC No. 0065273  
Medical Technologist

*John Patrick C. Padilla*  
JOHN PATRICK C. PADILLA, MD, DPSP  
PRC NO. 0089855  
Pathologist

Name: ESTALILLA, FROILAN RAY Company: SONIC SALES Date: 02/22/2020  
Age: 21 Gender: Male Requesting Physician: \_\_\_\_\_ J.O. No.: 0166401

**URINALYSIS**

Color	: Yellow	Albumin	: Negative
Character	: Clear	Sugar	: Negative
Specific Gravity	: 1.030		
Reaction	: 5.0		
Microscopic Examination			
Epithelial Cells	:	Casts	
Renal Cells	:	a. Hyaline	: /lpf
Mucus Threads	: Few	b. Fine	: /lpf
Bacteria	:	c. Coarse	: /lpf
Pus Cells	: 1-3	d. Waxy	: /lpf
RBC	: /hpf	e. WBC	: /lpf
Yeast Cells	: /hpf	Crystal	
Amorphous Urates	: Few	a. Urates	:
Amorphous Phosphates	:	b. Uric Acid	:
Others	:	c. Calcium Oxalate	:
		c. Triple Phosphate	:

Remarks: \_\_\_\_\_

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RESULT	NORMAL VALUES	RESULT	NORMAL VALUES
<b>HEMATOLOGY</b>			
Hemoglobin	157.0 M: 135 - 180 g/L F: 120 - 160 g/L	Platelet Count	321.0 140 - 440 x 10 <sup>9</sup>
Hematocrit	0.47 M: 0.40 - 0.54 F: 0.36 - 0.48	Reticulocyte Count	0.005 - 0.015
RBC Count	5.22 M: 4.5 - 6.0 x 10 <sup>12</sup> F: 4.0 - 5.5 x 10 <sup>12</sup>	ESR	M: 0 - 15 mm/hr F: 0 - 20 mm/hr
WBC Count	10.7 5 - 10 x 10 <sup>9</sup>	Bleeding Time	1 - 3 mins
<b>Differential Count</b>		Clotting Time	3 - 6 mins
Segmenters	0.61 0.55 - 0.65	Blood Type/Rh	
Lymphocyte	0.34 0.25 - 0.40	Malaria Smear	
Monocyte	0.03 0.02 - 0.06		
Eosinophils	0.02 0.01 - 0.05	Remarks	
Basophils	0.00 0.0 - 0.01		

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Pathologist

Name : ESTALILLA, FROILAN RAY	Company : SONIC SALES	Date: 02/22/2020
Age : 21	Gender : Male	File No.: 20-1280
Exam : Chest PA		Inv. No.: 0166401
Note: This report is based entirely on radiograph examination and should be correlated with clinical and laboratory findings.		
<b>RADIOGRAPHIC REPORT</b>		

The lungs are clear with no definite evidence of active infiltrates.  
Heart is within normal limits in size.  
Diaphragm and costophrenic sulci are intact.  
The rest of the visualized structures are unremarkable.

IMPRESSION:  
- RADIOGRAPHICALLY UNREMARKABLE CHEST FINDINGS

FEB 26 2020

*Teresa Canlas-Barrientos*

TERESA CANLAS-BARRIENTOS, MD, DPBR  
Radiologist



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DEPARTMENT OF HEALTH  
HEALTHPLUS DIAGNOSTIC SPECIALIST, INC.  
DOOR I STA. ANA REALTY BLDG., GUERRERO ST., DAVAQ CITY

Phone Number 082-227-1192

**DRUG TEST REPORT**

CCF No: 202002220004

Name: ESTALILLA, FROILAN RAY SUBANG

Birthdate: 10/20/1998 Age: 21 Gender: M

Transaction Date Time: 2/24/2020 11:10:00AM

Report Date Time: 2/24/2020 11:28:48AM

Test Method TEST KIT

**Purpose**

Private Employment

**Requesting Parties**

SONIC SALES AND DISTRIBUTION INC.

**Result**

Drug/Metabolite	Result	Remarks
METHAMPHETAMINE	NEGATIVE	
TETRAHYDROCANNABINOL	NEGATIVE	

Test Conducted By

Approved By

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Francine Andrea Tambor de Guia

Analyst

DR.

John Patrick C Padilla

Head of Laboratory

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Valid Within 12 Month/s from Transaction Date

This is a DOH-DDB IDTOMIS generated report



**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: <u>Friedman Ray Establie</u>		✓ B. Address: <u>Cathlamet Exports</u>		✓ C. Age: <u>21</u>	✓ D. Sex: <u>M</u>
✓ E. Employer Name and Address:					
F. Type of Specimen		✓ G. Reason for Test			
<input checked="" type="checkbox"/> Urine <input type="checkbox"/> Blood <input type="checkbox"/> Others (specify):		<input type="checkbox"/> Pre-employment <input type="checkbox"/> Return-to-Duty <input type="checkbox"/> Random <input type="checkbox"/> Mandatory <input type="checkbox"/> Follow-up <input type="checkbox"/> Reasonable Suspicion/Cause <input type="checkbox"/> Post-accident <input type="checkbox"/> Others (specify):			
H. Drug test to be Performed: <input type="checkbox"/> THC, COC, PCP, OPI, AMP <input type="checkbox"/> THC & MET Only <input type="checkbox"/> Others (specify):					

**STEP 2 COMPLETED BY COLLECTOR**

Read specimen temperature within 4 minutes	Specimen Collection: <input checked="" type="checkbox"/> Observed <input type="checkbox"/> Unobserved	Other Observation (Enter Remark)
Is temperature between 32°C and 38°C?	Specimen Sampling: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Split	
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Specimen Volume: <u>50</u> ml Physical Appearance Color: <u>YELLOW</u>	

**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.		SPECIMEN BOTTLE (S) RELEASED TO	
<input checked="" type="checkbox"/> Signature of Collector <u>GLADYS GRACE B. YALIN</u> (PRINT) Collector's Name (First, MI, Last)	Time of Collection: _____ AM/PM Date (mm/dd/yy): _____	Name of delivery Service Transferring Specimen to Lab: _____	
<b>RECEIVED AT LAB:</b> <input checked="" type="checkbox"/> Signature of Accessioner (PRINT) Accessioner's Name (First, MI, Last)	Date (mm/dd/yy): _____	<b>STATUS OF THE SPECIMEN</b> (a) Seal intact: <input type="checkbox"/> Yes <input type="checkbox"/> No (b) Transport device: (c) Description:	<b>SPECIMEN BOTTLE (S) RELEASED TO:</b> Signature of Receiving Person: (PRINT) Name (First, MI, Last) Date (mm/dd/yy):

**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 on this form and on the bottle is correct.		<input checked="" type="checkbox"/> Signature of Donor <u>Friedman Ray V. Establie</u> (PRINT) Donor's Name (First, MI, Last)	
<input checked="" type="checkbox"/> Contact No.: <u>09987622168</u>	Date of Birth: <u>10.20.2020</u> (mm/dd/yy)	Date (mm/dd/yy): <u>21.07.2020</u>	

**STEP 6 COMPLETED BY HEAD OF SCREENING LABORATORY**

In accordance with applicable Department of Health requirements, my determination/verification is:		<input type="checkbox"/> REFUSAL TO TEST BECAUSE <input type="checkbox"/> DILUTED <input type="checkbox"/> SUBSTITUTED <input type="checkbox"/> ADULTERATED <input type="checkbox"/> Others (specify):	
<input checked="" type="checkbox"/> NEGATIVE <input type="checkbox"/> POSITIVE <input type="checkbox"/> TEST CANCELLED	REMARKS: _____		
<input checked="" type="checkbox"/> Signature & Name of Analyst (First, MI, Last) <u>FRANCINE ANDREA T. DE GUIA</u>	<input checked="" type="checkbox"/> Signature & Name of Head of Laboratory (First, MI, Last) <u>DR. JOHN PATRICK C. PADILLA</u>	Date (mm/dd/yy): <u>FEB 25 2020</u>	

**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"/> FAILED TO CONFIRM - REASON: _____	
<input type="checkbox"/> CONFIRMED FOR <input type="checkbox"/> THC <input type="checkbox"/> MET <input type="checkbox"/> Others (specify):	REMARKS: _____		
<input checked="" type="checkbox"/> Signature & Name of Analyst (First, MI, Last)	<input checked="" type="checkbox"/> Signature & Name of Head of Laboratory (First, MI, Last)	Date (mm/dd/yy): _____	

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

In accordance with applicable Department of Health requirements, my determination/verification for the specimen (if tested) is:		<input type="checkbox"/> FAILED TO RECONFIRM - REASON: _____	
<input type="checkbox"/> RECONFIRMED FOR <input type="checkbox"/> THC <input type="checkbox"/> MET <input type="checkbox"/> Others (specify):	REMARKS: _____		
<input checked="" type="checkbox"/> Signature & Name of Analyst (First, MI, Last)	<input checked="" type="checkbox"/> Signature & Name of Head of Laboratory (First, MI, Last)	Date (mm/dd/yy): _____	

- Form DT-002A-Copy for the Donor
- Form DT-002B-Copy for the Collection Site
- Form DT-002C-Copy for the Laboratory
- Form DT-002D-Copy for the Confirmatory Laboratory (For Positive Sample)