

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD

Case No.:
ADJ10981870

REINA DELA HOUSSAYE
Claimant / Applicant,

AKA:
DOB: 12/29/1986
SSN: XXX-XX-5885

VS.

CGP MANAGEMENT CO., INC.
Employer / Insurance Carrier / Defendant.

(IF APPLICATION HAS BEEN FILED, CASE NUMBER MUST BE INDICATED REGARDLESS OF DATE OF INJURY)

SUBPOENA DUCES TECUM

(When records are mailed, identify them by using the above Case No. or attaching copy of the subpoena.)

NO PERSONAL APPEARANCE NECESSARY

Please refer to the In Bold summary description found below to identify the documents requested by this Subpoena

The People of the State of California Sends Greetings to: Custodian Of Records

JALIL MARIAN MD INC

WE COMMAND YOU to appear before **A NOTARY PUBLIC**

At **27450 Ynez Road, Suite 300, Temecula, CA 92591-4680**

On the 09th day of November, 2017, at 9 o'clock A. M. to testify in the above-entitled matter and to bring with you and produce the following described documents:

ANY AND ALL MEDICAL/TREATMENT RECORDS PERTAINING TO THE CARE, TREATMENT AND EXAMINATION OF CLAIMANT/APPLICANT REGARDLESS OF TIME PERIOD WHEN SERVICES WERE RENDERED.

(Do not produce X-rays unless specifically mentioned above.)

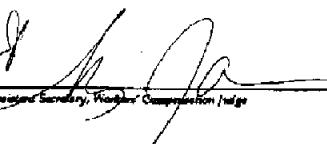
For failure to attend as required, you may be deemed guilty of a contempt and liable to pay to the parties aggrieved all losses and damages sustained thereby and forfeit one hundred dollars in addition thereto.

This subpoena is issued at the request of the person making the declaration on the reverse hereof, or on the copy which is served herewith.

Date 10/26/2017



WORKERS' COMPENSATION APPEALS BOARD
OF THE STATE OF CALIFORNIA


Secretary, Assistant Secretary, Worker Compensation Judge

Records copied and submitted to the designated court by RSP AND ASSOCIATES will be deemed as full compliance with this Subpoena.

CC: JOSHUA POTTER ESQ.

FOR INJURIES OCCURRING ON OR AFTER JANUARY 1, 1990 AND BEFORE, JANUARY 1, 1994:

If no Application for Adjudication of Claim has been filed, a declaration under penalty of perjury that the Employee's Claim for Workers' Compensation Benefits (Form DWC-1) has been filed pursuant to Labor Code Section 5401 must be executed properly.

**SEE REVERSE SIDE
[SUBPOENA INVALID WITHOUT DECLARATION]**

Order Ref #: 1350689

You may fully comply with this subpoena by mailing the records described (or authenticated copies, Evid Code 1561) to the person and place stated above within ten (10) days of the date of service of this subpoena. This subpoena does not apply to any member of the Highway Patrol, Sheriff's Office or City Police Department unless accompanied by notice from this Board that deposit of witness fee has been made in accordance with Government Code 68097.2 et seq.

Form 32 (r1) (Rev. September 10, 1998)

DECLARATION FOR SUBPOENA DUCES TECUM

Case No.: ADJ10981870

STATE OF CALIFORNIA, County of RIVERSIDE

The undersigned states:

That he / she is (one of) the representative(s) for the defendant in the action captioned on the reverse hereof.

That JALIL MARIAN MD INC has in his / her possession or under his / her control the documents described on the reverse hereof. That said documents are material to the issues involved in the case for the following reason:

To determine present and/or past physical condition; nature, extent and duration of sickness; injury, disability and/or necessity of further treatment.

Declaration for Injuries on or After January 1, 1990 and before January 1, 1994

That an Employee's Claim for Workers' Compensation Benefits (DWC Form 1) has been filed in accordance with Labor Code Section 5401 by the alleged injured worker whose records are sought, or if the worker is deceased, by the defendant(s) of the decedent, and that a true copy of the form filed is attached hereto. (Check Box if applicable and part of declaration below, See instructions on front of subpoena.)

I declare under penalty of perjury that the forgoing is true and correct.

Executed on 10/26/2017, at Temecula, California

James Polan
Signature 27450 Ynez Road, #300 Address (951) 694-5770 Telephone

R.S.P. AND ASSOCIATES FOR:
THE DEFENSE ATTORNEY:
/S/ HARRIGAN, POLAN, & KAPLAN
CYNTHIA BOLDY
P.O. BOX 7062
PASADENA, CA 91109
(626) 744-2122

DECLARATION OF SERVICE

STATE OF CALIFORNIA, County of:

I, the undersigned, state that I served the forgoing subpoena by showing the original and delivering a true copy thereof, together with a copy of the Declaration in support thereof, to each of the following named persons, personally, at the date and place set forth opposite each name.

Name of Person Served	Date	Place
<u>Angie Gurman</u>	<u>October, 27 2017</u>	<u>14350 WHITTIER BLVD # 200</u>

I declare under penalty of perjury that the forgoing is true and correct.

Executed on October, 27 2017 at WHITTIER, California

REINA DELA HOSSAYE
Signature

REINA DELA HOSSAYE, JALIL MARIAN MD INC



Order Ref #: **1350689**

Form 32 (r2) (Rev. September 10, 1998)

RSP & ASSOCIATES

CALIFORNIA'S PREMIER LITIGATION SUPPORT COMPANY

DECLARATION OF CUSTODIAN OF RECORDS

REGARDING: REINA DELA HOUSSAYE
AKA : REINA ANDREA DE LA HOUSSAYE
DOB : 12/29/1986
SSN : XXX-XX-5885

LOCATION: JALIL MARIAN MD INC

ORDER REF #:



* 1 3 5 0 6 8 9 C N R *

I, the undersigned, being the duly authorized Custodian of Records, or other qualified witness, and having authorization to certify the records declare:

THIS FORM MUST BE SIGNED
& RETURNED WHETHER OR
NOT YOU HAVE RECORDS.

THANK YOU!

CERTIFICATE OF RECORDS COPIED: *All records* requested by the attached Subpoena Duces Tecum / Authorization / Notice of Deposition were produced and delivered to RSP & Associates for duplication and conform to the Health Insurance Portability and Accountability Act.

No records or documents have been withheld or removed from this file. If items have been omitted, please explain:

CERTIFICATE OF NO RECORDS: A thorough search of our files, carried out under my direction and control revealed no documents requested in the attached Subpoena Duces Tecum / Authorization / Notice of Deposition. It is understood that records could exist under another name, spelling or classification but that with the information furnished, no such records could be found. (*Please check appropriate box(es) below*)

Medical Records Billing X-Rays / Films Employment Other

Requested documents have been:

Lost / Misplaced Never Existed Destroyed after _____ years

Other Comments _____

I certify under penalty of perjury under the laws of the State of California that the forgoing is true and correct.

Executed on 11/10/2017 at, (city/state) Whittier, California

Signature Angela Guzman Print Name ANGELA GUZMAN

Phone Number (562) 945-7691

27450 YNEZ ROAD • SUITE 300 • TEMECULA, CA 92591-4680

www.rsprecords.com • customerservice@rsprecords.com

Phone (800) 660-1107 • Fax (800) 660-6322

Phone (951) 694-5770 • Fax (951) 694-0020

RSP & ASSOCIATES

CALIFORNIA'S PREMIER LITIGATION SUPPORT COMPANY

REGARDING: REINA DELA HOUSSAYE
AKA : REINA ANDREA DE LA HOUSSAYE
DOB : 12/29/1986
SSN : XXX-XX-5885

LOCATION: JALIL MARIAN MD INC

ORDER REF #: 1350689

CERTIFICATE OF PROFESSIONAL PHOTOCOPIER

I, the undersigned, declare that R.S.P & Associates, Inc. is the attorney's or party without attorney's representative and that true copies were made of all the original records delivered to me by the Custodian of Records of the above indicated location.

I am an employee of R.S.P. & Associates, Inc., 27450 Ynez Road, Suite 300, Temecula, California 92591-4680; a Registered Professional Photocopier in Riverside County, Registration No.: PC19

Pursuant to Business and Professions Section 22462, I will maintain the integrity and confidentiality of information obtained under applicable codes and distribute the records copied by R.S.P. & Associates, Inc. to the authorized persons or entities.

The enclosed records have been verified for correctness as pertaining to the request/ patient/ student/ employee based on the following:

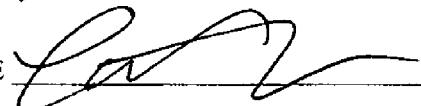
Date of Birth _____ Conversation with _____ of your office
 Social Security Number _____ No verifiable data available from client
 Middle Name/Initial _____ No verifiable data in file
 Date of Treatment and/or Accident _____ Other: _____

These records consist of : (Check One)

Any and All Records available
 Only Those Records Consistent with Specified Omissions

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE FOREGOING IS TRUE AND CORRECT.

Executed on 11-10-2017 at, (city/state) Whittier, CA

SIGNATURE 

PRINTED NAME Tatiana Gonzalez

Form 93 (Rev. April 15, 2002)

27450 YNEZ ROAD • SUITE 300 • TEMECULA, CA 92591-4680

rsprecords.com • rsp@rsprecords.com

PHONE (800) 660-1107 • FAX (800) 660-6322

PHONE (951) 694-5770 • FAX (951) 694-0020

Marian Jalil M.D. Inc.,
Adult Health Maintenance Checklist

Name: DELA HOUSSAYE, REINAH Age: 28 Sex: M Allergies: NKA

	2015	2016	2017	2018
C/R CA SCREEN FOBT Q 1 YEARS COLONOSCOPY Q 5/10 YEARS — NEVER FLEX SIG Q 5 YEARS				
PAP Q 1-3 YEARS <u>1/2014</u> BREAST EXAM MAMMOGRAM — never				
IMMUNIZATION DT BOOSTER Q 10 YEARS PNEUMOCOCAL Q 5 YEARS <u>No</u> INFLUENZA <u>No</u>				
PSA AT AGE 40+ EVERY YEAR <u>N/A</u>				
STOOL OB <u>Biannual NEVER</u>				
EYE EXAM <u>3/2015</u>				
SMOKING <u>Non Smoker</u>				

Practitioner: _____

MD / PA / NP

Marian Jalil M.D. Inc.,
Adult Health Maintenance Checklist

Name: Sela Horsy Reina Age: 27 Sex: M F Allergies: NICU

	2011	2012	2013	2014
<u>C/R Ca screen</u>				
FOBT Q 1 YEARS				
COLONOSCOPY Q 5/ 10 YEARS				
FLEX SIG Q 5 YEARS				
PAP Q 1-3 YARS				
BREAST EXAM				
MAMMOGRAM				
<u>INMUNIZATION</u>				
DT BOOSTER Q 10 YEARS				
PNEUMOCOCAL Q 5 YEARS				
PSA AT AGE40 + EVERY YEAR				

PRACTITIONER SIGNITURE:

MD DO PA NP

RIAN JALIL M.D.

CHRONIC PROBLEM / MEDICATION LIST

NAME

Reema Deekha Housseyn

ADDRESS

HOME PHONE

WORK PHONE

ALLERGIES NKA

PREVIOUS SURGERY

Pharmacy 5693-4474

Hysterectomy 1997

PROBLEMS: 1-----

2)-----

RISK FACTORS:

CIGARETTES Ø

ALCOHOL Ø

OTHERS DESCRIBE:

MEDICATIONS:

Glipizide 5mg TAB

120/14

4mcs

2/11/15

Ibuprofen 200 PRN

3.10.15 Ø

8/16/17

Lantus 40uU qAM 30apm

Metformin 1000T TABID

Robitussin 75 T qd

Hydrocodone 10g T PRN



REINA DELAHOUSAYE

Identification Number
JQO346M79294

Anthem Silver
73 HMO



APPLECARE MEDICAL GROUP - WHITIE
(800) 460-5051
MARIAN JALIL
(562) 945-7671

Effective Date 03/01/2015
Contract Code 1G05
Rx Bin 003858
Rx PCN A4
Rx Group Plan WXHA 040

Deductible \$1600 / \$3200
OOP \$5200 / \$10400
Coinsurance 20%
Rx Tier 1 / Rx Tier 2 \$15 / \$35
Rx Tier 3 / Rx Tier 4 \$60 / 20%

Select Rx List

Ded. and Coins. May Apply

Pathway X HMO



Rx

PRO

8/9/17
PCP
SLY
AS



MEMBERS: When submitting inquiries always include your Identification Number from the front of this card. Possession or use of this card does not guarantee payment.

PROVIDERS: Please submit claims to your local Blue Cross and/or Blue Shield plan. To ensure prompt claims processing, include the 3-digit alpha prefix that precedes the Identification Number listed on the front of this card.

File medical claims to:
P.O. Box 500007 Los Angeles, CA 90060-0007

anthem.com/ca

Customer Service (855) 634-3381
Provider Service (855) 854-1438
Pharmacist Questions (800) 824-0998
Pre Authorization (800) 274-7767
24/7 Nurseline (800) 249-3617
Coverage while traveling (800) 810-BLUE

Anthem Blue Cross is the trade name of Blue Cross of California, independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. Blue Cross names and symbols are registered marks of the Blue Cross Association.

Outside our service area, benefits may be limited to Urgent and Emergency care.

8/8/16
PCP
SLY
CO PP

8/21/16
PCP
SLY
CO PP

MARIAN JALIL, M.D., INC.
14350 E. WHITTIER BLVD. SUITE 200
WHITTIER, CA. 90605
PHONE (562) 945-7671
FAX (562) 945-7485

PLEASE PRINT CLEARLY

TODAY'S DATE: _____

PATIENT'S NAME Delatlaussaye Reina
(LAST) (FIRST)

DATE OF BIRTH 12/29/84 AGE 29 SEX F MARTIAL STATUS Sing/1

ADDRESS P.O. box 2012 CITY Whittier STATE CA ZIP 90606

HOME PHONE _____ CELL PHONE 562 842 5856

SOCIAL SECURITY 603 28 5885 CALIF DRIVER'S LIC. E2166706

ETHNICITY Hispanic RACE _____ LANGUAGE English

PATIENT'S EMPLOYER _____ OCCUPATION _____

ADDRESS _____ CITY _____ STATE _____ PHONE _____

SPOUSE OR GUARDIAN'S NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____ PHONE _____

EMERGENCY CONTACT Juli Delatlaussaye PHONE 562 309 5714

INSURANCE COMPANY _____ CERTIFICATE NUMBER _____

MEDICARE NUMBER _____ GROUP OR POLICY _____ MEDICAL _____

REFERRED BY _____ PHONE _____

PLEASE NOTE _____

PAYMENT FOR PROFESSIONAL SERVICES RENDERED ARE THE RESPONSIBILITY OF THE PATIENT AND/OR THE RESPONSIBLE PARTY.

I AUTHORIZE THE RELEASE OF ALL MEDICAL INFORMATION NECESSARY TO PROCESS ALL CLAIMS REGARDING MYSELF OR MY DEPENDENTS AND I ALSO AUTHORIZE THE INSURANCE COMPANY TO PAY THE SERVICES RENDERED BY DOCTOR MARIAN JALIL DIRECTLY TO HER.

Please note that if positive verification of your coverage cannot be made at this time, you will receive services today with the understanding that in the event that your coverage is not effective, you will be billed and held financially responsible for services rendered.

I have read and understood the above statement.

INSURED/PATIENT SIGNATURE [Signature]

DATE 07/20/18

IF PATIENT IS A MINOR /GUARDIAN SIGN HERE _____

DATE _____

MARIAN JALIL, M.D., INC.
14350 E. WHITTIER BLVD. SUITE 200
WHITTIER, CA. 90605
PHONE (562) 945-7671
FAX (562) 945-7485

PLEASE PRINT CLEARLY

TODAY'S DATE: 6/15/14

PATIENT'S NAME DeLaHassayc
(LAST)

Breing
(FIRST)

DATE OF BIRTH 12/29/1986 AGE 29 SEX F MARTIAL STATUS Single

ADDRESS # P.O. Box 2012 90610 CITY Whittier STATE CA ZIP 90605

HOME PHONE 562 8412 5854 CELL PHONE SAME

SOCIAL SECURITY 603 28 5885 CALIF. DRIVER'S LIC. E2144704

ETHNICITY Hispanic RACE SAME LANGUAGE English

PATIENT'S EMPLOYER _____ OCCUPATION _____

ADDRESS _____ CITY _____ STATE _____ PHONE _____

SPOUSE OR GUARDIAN'S NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____ PHONE _____

EMERGENCY CONTACT Julie DeLaHassayc PHONE 309 5714

INSURANCE COMPANY _____ CERTIFICATE NUMBER _____

MEDICARE NUMBER _____ GROUP OR POLICY _____ MEDICAL _____

REFERRED BY _____ PHONE _____

PLEASE NOTE _____

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Please note that if positive verification of your coverage cannot be made at this time, you will receive services today with the understanding that in the event that your
coverage is not effective, you will be billed and held financially responsible for services rendered.

I have read and understood the above statement.

INSURED/PATIENT SIGNATURE [Signature] DATE 6/15/14

IF PATIENT IS A MINOR /GUARDIAN SIGN HERE _____ DATE _____

MARIAN JALIL MD
14350 E. WHITTIER BLVD
SUITE 200
WHITTIER CA 90605-2148

Phone: 5629457671

08-23-2016

REINA DELAHOUSSAYE
P.O.BOX 2012
WHITTIER CA 90610

Patient: DELAHOUSSAYE, REINA
Account #: 2344

Statement

Svc Date	Code	MD	Description	Charges	Credits	Insurance Status	Payable Now
02-25-16	BalFwd		Balance before 02-25-16	100.00			0.00
06-15-16	99213	MJ	OFFICE OUTPT EST15 MIN	140.00		Pending	0.00
06-15-16	1159F	MJ	MEDICATION LIST DOCD IN MED	.00			0.00
06-15-16	1160F	MJ	RVW ALL MEDS BY RXNG PRCTI	.00			0.00
06-15-16	1170F	MJ	FUNCTIONAL STATUS ASSESSME	.00			0.00
06-15-16	3074F	MJ	MOST RECENT SYSTOLIC BLOO	.00			0.00
06-15-16	3080F	MJ	MOST RECENT DIASTOLIC BLOC	.00			0.00
07-14-16	InsAdj		Adj 3-31-15 code 99213		100.00		0.00
07-20-16	99213	MJ	OFFICE OUTPT EST15 MIN	140.00		Pending	0.00
07-20-16	1159F	MJ	MEDICATION LIST DOCD IN MED	.00			0.00
07-20-16	1160F	MJ	RVW ALL MEDS BY RXNG PRCTI	.00			0.00
07-20-16	1170F	MJ	FUNCTIONAL STATUS ASSESSME	.00			0.00
07-20-16	3074F	MJ	MOST RECENT SYSTOLIC BLOO	.00			0.00
07-20-16	3078F	MJ	MOST RECENT DIASTOLIC BLOC	.00			0.00

Current	Over 30	Over 60	Over 90	Acct. Balance	Amount Due
\$0.00	\$140.00	\$140.00	\$0.00	\$280.00	\$0.00

Reina 7/20
Delahoussaye

IS NOT

- PPO -

Need Inf.

She over 40.
each of the 2 last or



THE FOLLOWING ELIGIBILITY & BENEFIT INFORMATION AS REFLECTED AS OF (FAX DATE/TIME): Tuesday, June 14, 2016 15:35:55
MEMBER ID#: 346M79294 THE NEW MEMBER ID IS: 346M79294
MEMBER NAME: REINA DELAHOUSAYE MEMBER CODE: 20 DOB: 12/29/1986

EFFECTIVE DATE W/CURRENT MEDICAL PLAN: 01/01/2016

TERM DATE W/ MEDICAL PLAN: N/A

PRODUCT NAME: Pathway X P P O

PLAN CODE: N/A

GROUP NAME: MINIMUM COVERAGE PPO

GROUP#: 1X5P00

CONT CODE: 1X5P

PMG NAME: N/A

PMG PHONE#: N/A

EFFECTIVE DATE W/ PMG: N/A

TERM DATE W/ PMG: N/A

PRIMARY CARE PHYSICIAN: N/A

PCP PHONE#: N/A

CURRENT MEDICAL BENEFIT PLAN DESCRIPTION:

The plan deductible applies
and the plan covers 100% of the allowed amount

BENEFITS FOR AN OUT OF NETWORK OFFICE VISIT PHYSICIAN :

The plan deductible applies
and the plan covers 40% of the allowed amount

BENEFITS FOR AN IN NETWORK SPECIALIST OFFICE VISIT :

The plan deductible applies
and the plan covers 100% of the allowed amount

BENEFITS FOR AN OUT OF NETWORK SPECIALIST OFFICE VISIT :

The plan deductible applies
and the plan covers 40% of the allowed amount

CLAIMS BILLING ADDRESS: P O BOX 60007, LOS ANGELES, CA 90060-0007

Information disclaimer - The information does not pre-authorize payment. In order to receive benefits, the member must be covered at the time of service. The benefits information shown is not all-inclusive. It is limited to some coverage highlights. Other terms and limitations may apply even though such provisions are not indicated on this fax. All claims are subject to medical review according to the information submitted by the provider of service and are subject to benefit maximums and other terms of the member's contract. Please refer to the applicable benefit agreement to determine the appropriate payment amounts and any limitations or exclusions. If this is a HMO coverage, benefits must be authorized by the member's assigned medical group.



THE FOLLOWING ELIGIBILITY & BENEFIT INFORMATION AS REFLECTED AS OF (FAX DATE/TIME): Tuesday, June 14, 2016 15:35:55

MEMBER ID#: 346M79294

THE NEW MEMBER ID IS: 346M79294

MEMBER NAME: REINA DELAHOUSAYE

MEMBER CODE: 20

DOB: 12/29/1986

EFFECTIVE DATE W/CURRENT MEDICAL PLAN: 01/01/2016

TERM DATE W/ MEDICAL PLAN: N/A

PRODUCT NAME: Pathway X PPO

PLAN CODE: N/A

GROUP NAME: MINIMUM COVERAGE PPO

GROUP#: 1X5P00

CONT CODE: 1X5P

PMG NAME: N/A

PMG PHONE#: N/A

EFFECTIVE DATE W/ PMG: N/A

TERM DATE W/ PMG: N/A

PRIMARY CARE PHYSICIAN: N/A

PCP PHONE#: N/A

CURRENT MEDICAL BENEFIT PLAN DESCRIPTION:

The Individual in network Deductible is \$6,850.00 per plan year

This includes all medical and pharmacy claims This also includes all medical and dental Claims for Children on this policy

The Individual in network out of pocket maximum is \$6,850.00 per plan year

This includes all medical and pharmacy claims This also includes all medical dental and vision Claims for Children on this policy

The general basis of reimbursement for an in network Provider is 100%

The Individual out of network Deductible is \$13,700.00 per plan year

The Individual out of network out of pocket maximum is \$20,550.00 per plan year

The general basis of reimbursement for an out of network Provider is 40%

BENEFITS FOR AN IN NETWORK OFFICE VISIT PHYSICIAN :

For the first 3 visits

The plan covers 100% of the allowed amount

After 3 visits

CLAIMS BILLING ADDRESS: P O BOX 60007, LOS ANGELES, CA 90060-0007

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THE FOLLOWING ELIGIBILITY & BENEFIT INFORMATION AS REFLECTED AS OF (FAX DATE/TIME): Tuesday, June 14, 2016 15:35:55

MEMBER ID#: 346M79294

THE NEW MEMBER ID IS: 346M79294

MEMBER NAME: REINA DELAHOUSAYE

MEMBER CODE: 20

DOB: 12/29/1986

EFFECTIVE DATE W/CURRENT MEDICAL PLAN: 01/01/2016

TERM DATE W/ MEDICAL PLAN: N/A

PRODUCT NAME: Pathway X P P O

PLAN CODE: N/A

GROUP NAME: MINIMUM COVERAGE PPO

GROUP#: 1X5P00

CONT CODE: 1X5P

PMG NAME: N/A

PMG PHONE#: N/A

EFFECTIVE DATE W/ PMG: N/A

TERM DATE W/ PMG: N/A

PRIMARY CARE PHYSICIAN: N/A

PCP PHONE#: N/A

CURRENT MEDICAL BENEFIT PLAN DESCRIPTION:

CLAIMS BILLING ADDRESS: P O BOX 60007, LOS ANGELES, CA 90060-0007

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REINA DELAHOSAYE

Identification Number
JQO346M79294Effective Date 03/01/2015
Contract Code 1G05
Rx Bin 003858
PCN A4
Rx Group WXHA
Plan 040Anthem Silver
73 HMOALLIED PACIFIC OF CALIFORNIA IPA
(626) 262-0268
JAMES H SONG
(626) 581-8330Deductible \$1600 / \$3200
OOP \$5200 / \$10400
Co-Insurance 20%
Rx Tier1/Rx Tier2 \$15 / \$35
Rx Tier3/Rx Tier4 \$60 / 20%

Select Rx List

Ded. and Coins. May Apply

Pathway X HMO



Rx

(855) 854-1438

PCP Visit
PFF-3/15
\$0 * 400
Appicare 3/15

3/18/15

PCP Visit

PFF 3/15
10 * 400Appicare
3/156-15-2015
PCP Visit
PFF Visit
COPAY
COPAYTR " 1 "
3 b. apt. m 1 "
mild cold
up.ET P
2016671117X P O
X dated
over

VERBAL COMMUNICATION WITH FAMILY AND OTHERS INVOLVED IN YOUR CARE

Name: Ryina Delatrousse DOB: 12/29/84

This form DOES NOT cover access to or release of medical records. This form may be used to document those individuals you want to communicate with providers and staff at MARIAM JALIL, M.D. in person or on the phone, in regards to the coordination or payment for your care. For access or copies of records to one of the individuals you designate, you must complete an Authorization for Disclosure of Protected Health Information for each separate disclosure or have an effective Advance Healthcare Directive or other valid legal document on file.

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

Name:	Relationship to Patient:	Date of Birth:	Type of Information (Initial)			
			ALL	Scheduled Appoint.	Medical	Billing/Insurance
<u>Julie Delatrousse</u>	<u>Mother</u>	<u>7/28/59</u>	<u>Initial</u>	<u>Initial</u>	<u>Initial</u>	<u>Initial</u>
			<u>Initial</u>	<u>Initial</u>	<u>Initial</u>	<u>Initial</u>
			<u>Initial</u>	<u>Initial</u>	<u>Initial</u>	<u>Initial</u>
			<u>Initial</u>	<u>Initial</u>	<u>Initial</u>	<u>Initial</u>
			<u>Initial</u>	<u>Initial</u>	<u>Initial</u>	<u>Initial</u>
			<u>Initial</u>	<u>Initial</u>	<u>Initial</u>	<u>Initial</u>

Please describe any specific Instructions or Limitations:

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify your physician's office if you wish to alter the designations above.

Signature of Patient or Representative: JL Date: 6/15/11

Relationship to Patient: Mother

To revoke this authorization, please send a written request with a copy of this form to *The Health Information Services Department - Release of Information* at the address below.

Mariam Jalil, M.D., Inc.
14950 E. Whittier Blvd., Suite 200
WHITTIER, CALIFORNIA 90605

APPT. LABEL

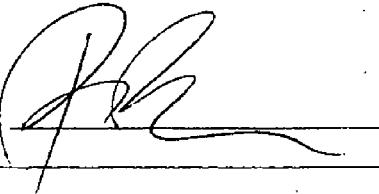
ADVANCE HEALTH CARE DIRECTIVE STATUS

I have been informed of my right to formulate advance directives concerning health care decisions, and I have been provided with information regarding the execution of an Advance Health Care Direction.

Please check one of the following:

- I have completed an Advance Health Care Directive and provided a copy for inclusion in my medical record.
 - I will provide a copy of my previously executed Advance Health Care Directive to MARIAN JALIL, MD, INC. for inclusion in my medical record.
 - I have not executed an Advance Health Care Directive and I am not interested in further information.
 - I am interested in formulating an Advance Health Care Directive and will discuss my options with my primary care provider at my next appointment.
-

Patient Signature:



Date: 6/15/16

Received By:

Date:

Marian Jalil, MD, Inc.
14350 E. Whittier Blvd., Suite 200
Whittier, California 90605

PIH HEALTH
PO BOX 1217
WHITTIER CA 90609-1217
PIH HEALTH PHYSICIANS
Remittance Advice Summary
562-789-5401 Option #3

PAGE 1

File

MARIAN JALIL MD INC
14350 E WHITTIER BLVD
#200
WHITTIER, CA 90605

Check # XXXXX \$0.00

Check Date 04/16/2014

PROVIDER 8283 01 JALIL MARIAN MD
VENDOR 8283 01
TAX ID 953991472

Please call PIH Health at the phone number above if any of the following claims are not finalized to your expectation.

Patient Name	Member #	Healthplan	LOB	Referral #	From to date	Claim #	Account #	cap				
DELAHOUSSAYE, REINA A	378042 01	A2	CO	0	01/22/2014 01/22/2014	14081E018E	79711					
CPT	MD Units	D. O. S.	Proc Description			Amount Billed	Amt Above Allowed	Copay Amount	Amount Allowed	Paid Amount	Expl CD	Cap
36415	I	01/22/2014	DRAWING BLOOD...			\$15.00	\$15.00	\$0.00	\$0.00	\$0.00	T N	

Member not Eligible on DOS

CLAIM TOTALS

BILLED	\$15.00
COB	\$0.00
REJ ABVE CNTRCT AMT DO NOT BILL MBR	\$15.00
COPAY	\$0.00
Sequestration Rate Reduction	\$0.00
ALLOWED	\$0.00
PAID	\$0.00

EL92 COM-Postdates eligibility with Plan

Patient Name	Member #	Healthplan	LOB	Referral #	From to date	Claim #	Account #	cap				
DELAHOUSSAYE, REINA A	378042 01	A2	CO	0	01/22/2014 01/22/2014	14081E01A1	79710					
CPT	MD Units	D. O. S.	Proc Description			Amount Billed	Amt Above Allowed	Copay Amount	Amount Allowed	Paid Amount	Expl CD	Cap
99305	I	01/22/2014	NURSING FACILITY CARE, INIT			\$180.00	\$180.00	\$0.00	\$0.00	\$0.00	T N	
1159F	I	01/22/2014	MEDICATION LIST DOCUMENTED IN MEDICAL REC			\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	T N	
1160F	I	01/22/2014	REVIEW OF ALL MEDICATIONS BY A PRESCRIBING			\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	T N	
1170F	I	01/22/2014	FUNCTIONAL STATUS ASSESSED (COA, RA)			\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	T N	
3074F	I	01/22/2014	MOST RECENT SYSTOLIC BLOOD PRESSURE LESS T			\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	T N	
3078F	I	01/22/2014	MOST RECENT DIASTOLIC BLOOD PRESSURE LESS			\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	T N	

Member not Eligible on DOS

Disney
Santa Barbara
The Disney
Santa Barbara
Disneyland
California

HEALTH
PO BOX 1217
WHITTIER CA 90609-1217
PIH HEALTH PHYSICIANS
Remittance Advice Summary
562-789-5401 Option #3

PAGE 2

Check # XXXXX \$0.00

Check Date 04/16/2014

MARIAN JALIL MD INC

PROVIDER 8283 01 JALIL MARIAN MD
VENDOR 8283 01
TAX ID 953991477

Please call PIH Health at the phone number above if any of the following claims are not finalized to your expectation.

Patient Name	Member #	Healthplan	LOB	Referral #	From to date	Claim #	Account #
--------------	----------	------------	-----	------------	--------------	---------	-----------

cap1

CLAIM TOTALS

BILLED	\$180.00
COB	\$0.00
REJ ABVE CNTRCT AMT DO NOT BILL MBR	\$180.00
COPAY	\$0.00
Sequestration Rate Reduction	\$0.00
ALLOWED	\$0.00
PAID	\$0.00

EL92 COM-Postdates eligibility with Plan

PROVIDER TOTALS

BILLED	\$195.00
COB	\$0.00
REJ ABVE CNTRCT AMT DO NOT BILL MBR	\$195.00
COPAY	\$0.00
Sequestration Rate Reduction	\$0.00
ALLOWED	\$0.00
PAID	\$0.00

MARIAN JALIL MD INC

JALIL MARIAN, MD

\$0.00

In order to file a Formal Written dispute:

Non-contracted providers Please refer to www.brighthealth.com for our Claims Dispute Resolution Process for filing requirements.

Contracted providers Please review the 'Downstream Provider Notice Claims Settlement Practices & Dispute Resolution Mechanism' in your contract.

MARIAN JALIL, M.D., INC.
14350 E. WHITTIER BLVD. SUITE 200
WHITTIER, CA. 90605
PHONE (562) 945-7671
FAX (562) 945-7485

PLEASE PRINT CLEARLY

TODAY'S DATE: 2/11/15

PATIENT'S NAME De latbussaye Reina
(LAST) (FIRST)

DATE OF BIRTH 12/29/86 AGE 28 SEX F MARTIAL STATUS Single

ADDRESS 8210 Broadway CITY Whittier STATE CA ZIP 90606

HOME PHONE 7 CELL PHONE (62) 842 5856

SOCIAL SECURITY 603 285885 CALIF.DRIVER'S LIC. 62 166704

ETHNICITY _____ RACE HIS LANGUAGE English

PATIENT'S EMPLOYER _____ OCCUPATION _____

ADDRESS _____ CITY _____ STATE _____ PHONE _____

SPOUSE OR GUARDIAN'S NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____ PHONE _____

EMERGENCY CONTACT Julio Art Hwy PHONE 562 3095714

INSURANCE COMPANY _____ CERTIFICATE NUMBER _____

MEDICARE NUMBER _____ GROUP OR POLICY _____ MEDICAL _____

REFERRED BY _____ PHONE _____

PLEASE NOTE _____

PAYMENT FOR PROFESSIONAL SERVICES RENDERED ARE THE RESPONSIBILITY OF THE
PATIENT AND/OR THE RESPONSIBLE PARTY.

I AUTHORIZE THE RELEASE OF ALL MEDICAL INFORMATION NECESSARY TO PROCESS ALL CLAIMS
REGARDING MYSELF OR MY DEPENDENTS AND I ALSO AUTHORIZE THE INSURANCE COMPANY TO
PAY THE SERVICES RENDERED BY DOCTOR MARIAN JALIL DIRECTLY TO HER.

Please note that if positive verification of your coverage cannot be made at this time, you will receive services today with the understanding that in the event that your
coverage is not effective, you will be billed and held financially responsible for services rendered.
I have read and understood the above statement.

INSURED/PATIENT SIGNATURE MM DATE 2/11/15

IF PATIENT IS A MINOR /GUARDIAN SIGN HERE _____ DATE _____

MARIAN JALIL, M.D., INC.
14350 E. WHITTIER BLVD. SUITE 200
WHITTIER, CA. 90605
PHONE (562) 945-7671
FAX (562) 945-7485

PLEASE PRINT CLEARLY

TODAY'S DATE: 1/22/14

PATIENT'S NAME

DELAHOUESSAYE REINA

(LAST)

(FIRST)

DATE OF BIRTH

12/29/86

AGE

27

SEX

F

MARITAL STATUS

S

ADDRESS

8210 BROADWAY

CITY

Whittier

STATE

CA

ZIP

90606

HOME PHONE

5626927675

CELL PHONE

5623958053

SOCIAL SECURITY

603-28-5885

CALIF. DRIVER'S LIC.

F2166706

exp 10/29

PATIENT'S EMPLOYER

STUFF PIZZA

OCCUPATION

MANAGER

ADDRESS

11104 Whittier

CITY

Whittier

STATE

CA

PHONE

5626991045

SPOUSE OR GUARDIAN'S NAME

RELATIONSHIP

ADDRESS

CITY

STATE

PHONE

EMERGENCY CONTACT

Julie Delahoussaye

PHONE

5623095714

INSURANCE COMPANY

Aetna

CERTIFICATE NUMBER

BBTN65GA

MEDICARE NUMBER

GROUP OR POLICY

MEDICAL

REFERRED BY

PHONE

PLEASE NOTE

PAYMENT FOR PROFESSIONAL SERVICES RENDERED ARE THE RESPONSIBILITY OF THE
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I AUTHORIZE THE RELEASE OF ALL MEDICAL INFORMATION NECESSARY TO PROCESS ALL CLAIMS
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understanding that in the event that your coverage is not effective, you will be billed and held financially responsible for services rendered.
I have read and understood the above statement.

INSURED/PATIENT SIGNATURE

DATE

1/22/14

IF PATIENT IS A MINOR/GUARDIAN SIGN HERE

DATE



Aetna Value NetworkSM
Aetna Small Group HMO

AETNA SMALL GROUP

ID# BBTNG5GA

MEMBER NAME

REINA A DELAHOUSSAYE

GRP# 413913

RX BIN# 610502

DR 40
SP 50

BRIGHT HEALTH PHYSICIANS IPA DIVISION
DR 562-945-7671 103968

VALID: 11/01/2012

www.aetna.com

Payer ID # 60054

You must choose a primary care physician (PCP) and referrals are required. Your PCP must issue referrals before the service except for direct access benefits or emergencies. If you do not obtain referrals, you will be responsible for the cost of the service.
Emergency: Call 911 or go to nearest emergency facility.
Notify Member Services as soon as possible after treatment.
This card does not guarantee coverage.

AETNA HEALTH OF CALIFORNIA INC.
PO BOX 14079 • LEXINGTON, KY 40512-4079

MEMBER SERVICES
PROVIDERS CALL
BEHAVIORAL HEALTH
RX MEMBER SERVICES

888-70-AETNA
800-624-0756
800-886-1578
888-792-3862

PHAS
BHP

Per Janet
et 11-1-2012

12mos
Buy Back
Cost 40.⁰⁰
10%.

8-7-2014 Jan

8-8-14 Nov 2014 12/31/13

11-11-13
12-31-13
D3D151033

1/22/14
ET 11/11/13
PP mail
BHP
CER 10/11/13

Marian Jalil, M. D. Inc.
14350 E. Whittier Blvd., Suite 200
Whittier, CA 90605
Phone: (562) 945-7671
Fax: (562) 945-7485

Please Print Clearly

Today's Date: _____

Patient's Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone _____ Age _____ Sex _____ Marital Status _____

Social Security _____ California Driver's Lic. _____

Your Employer _____ Your Occupation _____

Address _____ City _____ State _____ Phone _____

Spouse or Guardian's Name _____ Relationship _____

Address _____ City _____ State _____ Phone _____

Nearest Relative Not Living with You _____ Phone _____

Insurance _____ Certificate Number _____

Medicare Number _____ Group/Policy _____ Medical _____

Referred By _____ Phone _____

PLEASE NOTE

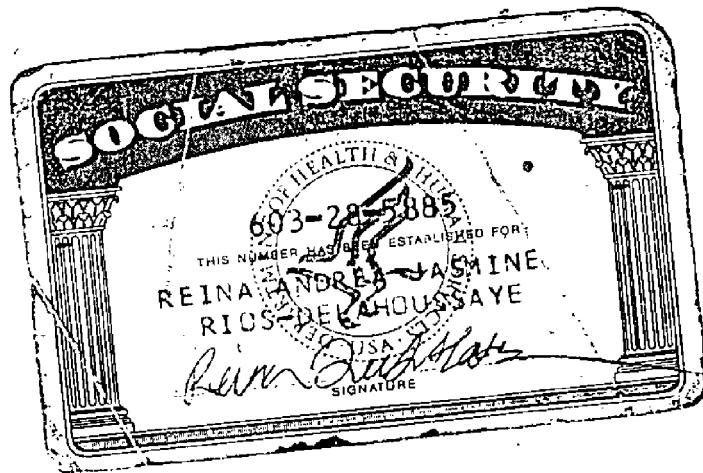
Payment for professional services rendered are the responsibility of the patient and/or the responsible party.

I authorize the release of all medical information necessary to process all claims regarding my dependents or myself and I also authorize the insurance company to pay the services rendered by Doctor Marian Jalil directly to her.

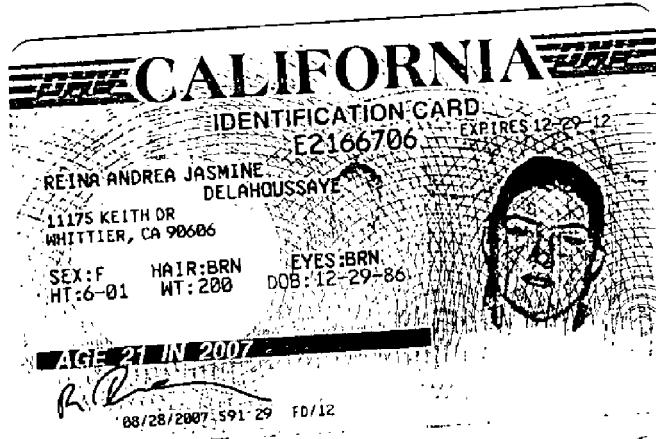
Please note that positive verification of your coverage cannot be made at this time. You will receive services today with the understanding that in the event that your coverage is not effective, you will be billed and held financially responsible for services rendered.

I have read and understood the above statements

Patient's Signature



Aetna



PLEASE
DO NOT
STAPLE
IN THIS
AREA

SS NMM 80070804 S 5/089

ALLIED PHYSICIANS OF CALIF.
1680 S. GARFIELD AVE
SUITE 201
ALHAMBRA, CA 91801
626/282-0288

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP FECA OTHER (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) BLK LUNG (SSN) (ID)										14. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 603285885-10										
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DELAHOUSSEY, RETNA										3. PATIENT'S BIRTH DATE MM DD YY SEX 12 29 1986 M F X										
5. PATIENT'S ADDRESS (No., Street) 14410 FEDFORD DR										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										
CITY WHITTIER					STATE CA					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/> Part-Time <input type="checkbox"/>										
ZIP CODE 90604		TELEPHONE (Include Area Code) (562) 7777414								10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										11. INSURED'S POLICY GROUP OR FECA NUMBER 0005900										
12. OTHER INSURED'S POLICY OR GROUP NUMBER										12. INSURED'S DATE OF BIRTH MM DD YY SEX MM DD YY M F										
13. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M F										13. EMPLOYER'S NAME OR SCHOOL NAME										
14. INSURANCE PLAN NAME OR PROGRAM NAME										14. INSURANCE PLAN NAME OR PROGRAM NAME ALLIED PHYSICIAN OF CALIF.										
15. RESERVED FOR LOCAL USE										15. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete Item 9-14.										
16. PATIENT'S SIGNATURE ON FILE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY										
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE MARIAN JALIL										17a. I.D. NUMBER OF REFERRING PHYSICIAN 1G850446										
18. RESERVED FOR LOCAL USE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										
19. RESERVED FOR LOCAL USE										19. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										
20. RESERVED FOR LOCAL USE										20. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 250.02 3. 382.9 4. 796.3										21. PRIOR AUTHORIZATION NUMBER										
22. RESERVED FOR LOCAL USE										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.										
23. RESERVED FOR LOCAL USE										23. PRIOR AUTHORIZATION NUMBER										
24. A DATE(S) OF SERVICE FROM To MM DD YY MM DD YY										B C D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER						E DIAGNOSIS CODE		F G H I J K \$ CHARGES DAYS OR UNITS EPSDT Family Plan EMR COB OB OA408630	RESERVED FOR LOCAL USE	
10162006		10162006		11		99213				1234		60.00	1	1801897103						
10162006		10162006		11		36415				1234		15.00	1	1801897103						
25. FEDERAL TAX ID. NUMBER SSN EIN 95-3991477										26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For Govt. Claims, see back) 27969 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						28. TOTAL CHARGE \$ 75.00		29. PAYMENT STATUS 05/01/2007		30. BALANCE DUE \$ 75.00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereto.) MARIAN JALIL M.D., INC.										32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)						33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # MARIAN JALIL M.D., INC. 14350 E. WHITTIER BLVD SUITE 200 WHITTIER CA 90605				
SIGNED 05 Oct 2007										PIN 1801897103 OB OA408630										

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



Attn: Billing Department

1st Request _____
2nd Request _____

Dear Provider:

Upon careful review, we are returning your claim(s), which are pending for the following reason(s):

- Patient is not a member of our Medical Group/IPA. Forward to: _____
 Please submit a copy of the patient's Health Plan ID card.
 Member is not eligible for benefits for the month of service.
(Effective: _____ Term: _____)
 Please verify correct Date of Service
 Newborn Billing requires Mother's Insurance Information.
 No record of Treatment Authorization.
 Need Patient Progress and/or Critical Report
 Need Invoice
 Need Hospital Records
 Need HCFA-1500/UB-92 form
 Need Prenatal 1,2,3 reports
 Please add CPT code on claim form
 This claim is not our responsibility. Please forward to _____
 Other: _____

Item(s) requested above must be received within fifteen (15) working days from the date of this letter or your response will be treated as a new claim.

Please submit the request to:
Network Medical Management
Claims Mailbox A
1680 S. Garfield Ave.
Alhambra, CA 91801

Respectfully,

Claims Department

ADULT HEALTH MAINTENANCE CHECKLIST

NAME:	AGE:	SEX: M F	ALLERGIES:				
YEAR:		LAST	2005	2006	2007	2008	2009
PHYSICAL EXAM/PREVENTIVE SCREENING							
HISTORY & PHYSICAL INITIAL (AT FIRST VISIT)							
AGE 19-39 Q3YRS							
AGE 40-64 Q2YRS							
AGE 65 + Q1YR							
BREAST EXAM INITIAL (AT FIRST VISIT)							
AGE 20-40 Q3YRS							
AGE 40 + Q1YR							
HIGH RISK 35 +							
PROSTATE EXAM AGE 40 + Q1YR							
RECTAL EXAM FOR OCCULT BLOOD AGE 50+							
SIGMOIDOSCOPY AGE 50 + Q3-5 YR							
CHOLESTEROL INITIAL (AT FIRST VISIT)							
AGE 19-39 Q3YRS							
AGE 40-64 Q2YRS							
AGE 65 + Q1YR							
MAMMOGRAPHY AGE 40-49 Q2YRS							
AGE 50 + Q1YR							
HIGH RISK 35 +							
PAP SMEAR/PELVIC EXAM INITIAL (AT FIRST VISIT)							
Q YR X 3. THEN EVERY 1-3 YRS							
EKG BASELINE : BETWEEN 40 & 50 YRS							
INMMUNIZATION							
DT BOOSTER Q 10 YRS							
PPD HIGH RISK							
INFLUENZA VACCINE AGE 65 + Q1YR							
OR HIGH RISK							
(IE: CARDIAC OR PULMONARY DIS., CRF, DM OR IMMUNOSUPPRESSION)							
PNEUMOCOCCAL VACCINE AGE 65 +							
OR HIGH RISK							
(IE: CHRONIC ILLNESSES: CARDIOVASC DIS, DM)							
HEALTH EDUCATION							

Marian Jalil M.D. Inc.
14350 E. Whittier Blvd. Suite 200
Whittier, Ca. 90605
Phone: (562) 945-7671
Fax: (562) 945-7485

Please Print Clearly

Today's date: 4-10-06

Patient's Name Reina Delatoussaye Date Of Birth 12-29-86

Address 14410 Terrell Dr. City Whittier State CA Zip 90604

Phone (562) 277-7414 Age 19 Sex Female Marital Status Single

Social Security 603-28-5885 California Driver's Lic. IV/1T

Your Employer IV/1T Your Occupation N/A

Address _____ City _____ State _____ Phone _____

Spouse or Guardian's Name Shawn Relationship _____

Address _____ City _____ State _____ Phone _____

Nearest Relative Not Living with you Reina Delatoussaye Phone (562) 841-6056

Insurance _____ Certificate Number _____

Medicare Number _____ Group/ Policy _____ Medical _____

Referred By _____ Phone _____

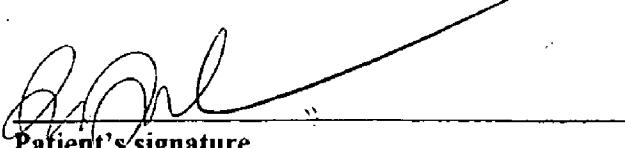
Please Note

Payment for professional services rendered are the responsibility of the patient and/or the responsible party.

I authorize the release of all medical information necessary to process all claims regarding my dependents or myself and I also authorize the insurance company to pay the services rendered by Doctor Marian Jalil Directly to her.

Please note that positive verification of your coverage cannot be made at this time you will receive services today with the understanding the event that your coverage is not effective, you will be billed and held financially responsible for services rendered.

I have read and understood the above statements.



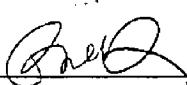
Patient's signature

(HEREINAFTER CALLED ATTENDING PHYSICIAN).

WITH REGARD TO MEDICAL CARE AND SERVICES PROVIDED OR TO BE PROVIDED, IT IS AGREED THAT: THE ATTENDING PHYSICIAN WILL PROVIDE MEDICAL CARE AND SERVICES TO THE PATIENT TO THE BEST OF HER/HIS SKILLS AND KNOWLEDGE, WHICH MEDICAL CARE IN THE LIGHT OF CIRCUMSTANCES IS POSSIBLE AND PRACTICAL. THE PATIENT WILL COOPERATE FULLY WITH THE ATTENDING PHYSICIAN BY OBTAINING SUCH MEDICATION AS PRESCRIBED, BY FOLLOWING THE INSTRUCTIONS OF THE ATTENDING PHYSICIAN, BY ADHERING TO SUCH TREATMENT REGIMEN OR COURSE OF ACTION AS MAY BE SET FORTH, AND BY PAYING ALL THE FEES AND CHARGES IN FULL AS BILLED OR AS PROVIDED BY PRIOR SPECIAL ARRANGEMENTS. IT IS AGREED THAT: BECAUSE OF DIFFERENCE IN HUMAN CONSTITUTION AND RESPONSE, IT IS IN NO WAY POSSIBLE TO WARRANT THE OUTCOME OF SUCH MEDICAL CARE AND SERVICE. IN THE EVENT OF ANY CONTROVERSY BETWEEN THE PATIENT OR DEPENDENT (WHETHER OR NOT A MINOR) OR THE HEIRS-AT-LAW OR PERSONAL REPRESENTATIVE OF A PATIENT AS THE CASE MAY BE, AND THE ATTENDING PHYSICIAN (INCLUDING AGENTS AND EMPLOYEES), INVOLVING A CLAIM IN TORT OR CONTRACTUAL, THE SAME SHALL BE SUBMITTED TO ARBITRATION. WITHIN FIFTEEN (15) DAYS AFTER THE PATIENT OR ATTENDING PHYSICIAN SHALL GIVE NOTICE TO THE OTHER OF DEMANDING ARBITRATION OF SUCH CONTROVERSY, THE PARTIES TO THE CONTROVERSY SHALL EACH APPOINT AN ARBITRATOR AND GIVE NOTICE OF SUCH AN APPOINTMENT TO THE OTHER. WITHIN A REASONABLE AMOUNT OF TIME AFTER SUCH NOTICES HAVE BEEN GIVEN, THE TWO ARBITRATORS, SO SELECTED, SHALL SELECT A NEUTRAL ARBITRATOR AND GIVE NOTICE OF THE SELECTION THEREOF TO THE PARTIES. THE ARBITRATORS SHALL HOLD A HEARING WITHIN A REASONABLE TIME FROM THE DATE OF NOTICE OF SELECTION OF NEUTRAL ARBITRATOR. ALL NOTICES OR OTHER PAPERS REQUIRED TO BE SERVED SHALL BE SERVED BY UNITED STATES MAIL EXCEPT AS PROVIDED HEREIN, THE ARBITRATION SHALL BE CONDUCTED IN ACCORDANCE WITH AND GOVERNED BY THE PROVISIONS OF TITLE 9 OF THE CALIFORNIA CODE OF CIVIL PROCEDURE. THE PATIENT MAY WITHDRAW FROM THE ARBITRATION PORTION OF THIS AGREEMENT WITHIN THIRTY (30) DAYS FROM THE DATE OF THIS AGREEMENT BY NOTIFICATION OF HIS INTENT TO DO SO TO THE ATTENDING PHYSICIAN BY REGISTERED MAIL. BY OUR SIGNATURES, WE CONSENT TO THIS AGREEMENT.

DATE 4/10/07

PATIENT



IF PATIENT IS A MINOR A GUARDIAN SHOULD SIGN HERE

MARIAN JALIL M.D.
SPECIALIST INTERNAL MEDICINE
14350 E. WHITTIER BLVD. SUITE 200
WHITTIER, CALIFORNIA 90605

562- 945-7671

DEAR PATIENT

Positive verification of your coverage cannot be made at this time
you will receive services today with the understanding that in the event that
your coverage is not effective you will be billed and held financially
responsible for services rendered

Subscriber's Name

Insurance Carrier

X
Patient's Name

Employer group

Permanent Address

Group Policy Number

City, State, Zip

Telephone Number

I HAVE READ THE ABOVE AND UNDERSTAND MY POSSIBLE FINANCIAL
RESPONSIBILITY TO _____ AND HEREBY AFFIX MY
SIGNATURE AS AN ACKNOWLEDGEMENT OF THIS UNDERSTANDING

X R.D.M.
PATIENT Signature

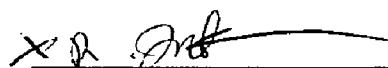
X 4-10-06
Date

Receptionist, Office Personnel

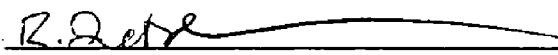
MARIAN JALIL, M.D. INC.
14350 Whittier Blvd. #200
Whittier, CA 90605
(213) 945-7671

**AUTHORIZATION TO PAY MEDICAL AND SURGICAL BENEFITS DIRECTLY TO
THE ATTENDING PHYSICIAN**

I hereby authorize _____ to make all payments directly to
MARIAN JALIL, M.D. for all surgical and medical expense benefits otherwise payable
to me for this period of treatment. I understand that I am financially responsible to
MARIAN JALIL, M.D. for all charges not covered by my insurance benefits. A
photocopy of this assignment shall be considered as valid as the original.



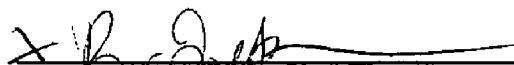
Insured's Signature



Patient or Guardian's Signature

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize MARIAN JALIL, M.D. to furnish information to insurance carriers
concerning this illness. A photocopy of this authorization shall be considered as valid
as the original.



Patient or Guardian's Signature

CONSENT FOR TREATMENT

I hereby consent to and authorize the administration of all diagnostic and therapeutic treatment for me or my minor child that may be necessary in the judgement of the attending physician and/or medical personnel.

I acknowledge that I have read this consent form and understand its contents. I have had an opportunity to discuss it, and any questions I have had, have been answered to my complete satisfaction.

Being the parent/legal guardian of the minor patient _____ I consent to the said procedures being performed whether I am present or not and this, my signature hereunder, shall be full and sufficient authority. Should the need arise to perform services not set out above, _____ May obtain consent by telephone or by letter granting such consent.

Witness



Patient's Signature

4-10-09
Date

Parent or Legal Guardian's Signature

CONSENTIMIENTO PARA TRATAMIENTO

Por la presente doy mi consentimiento y autorizo que se imparta todo tratamiento terapéutico y diagnóstico para mí o para mi hijo(a) menor de edad, según sea necesario en la opinión del personal médico y/o el médico que éste prestando dicha atención.

Reconozco que he leido este formulario de consentimiento para tratamiento y entiendo su contenido. He tenido la oportunidad de discutirlo, y las preguntas que he hecho se me han contestado a mi completa satisfaccion.

Siendo el padre/guardian legal del paciente menor de edad, yo doy mi consentimiento para que los procedimientos necesarios se han hechos este o no presente. Estoy de acuerdo que mi firma debe ser suficiente autorizacion. En caso de que se origine la necesidad de suministrar servicios no descritos previamente, _____ Puede obtener el consentimiento por telefono o por medio de una carta otorgando este consentimiento.

Testigo

Firma del Paciente

Fecha

Firma del Padre, Madre, o Guardian legal

Making An Advance Directive

What happens if people become too sick to make their own medical decisions? Someone must decide when to start treatment, when not to start it, or when to stop it. Family members and doctors usually make decisions when the patient can't. Sometimes they are not sure what is best. Sometimes they disagree. That's when it would be good to know what the patient would have wanted and who the patient would have wanted to make these decisions. That's why it will help your family, close friends, and physicians, if you have filled out an advance directive. And having one empowers you—if you've made your wishes clear, they're more likely to be followed.

What's an advance directive?

An advance directive is a paper you fill out. You write in advance what you want done in case you have a serious injury or illness and aren't able to speak for yourself. You can use an advance directive in two ways.

First, you can name a relative or friend you trust as your "agent" to make medical decisions for you if you can't make them yourself. In California, this type of directive is called a Durable Power of Attorney for Health Care.

Second, you can write down when you would or wouldn't want to be treated if you became very sick. And you can describe what kinds of treatment you would and wouldn't want. People feel differently about how much treatment they want under different conditions. By filling out what is often called a "living will," you can let your family, friends, and physicians know how you feel. The type of living will that is recognized by statute in California for patients who are terminally ill or permanently unconscious is called a Natural Death Act Declaration. You can also write your wishes about treatment in a nonstatutory Living Will or in a Durable Power of Attorney for Health Care, with or without naming an agent.

Which one should I use?

Do you have someone you can name as your agent to make treatment decisions if you can't make them yourself? If the answer is yes, a Durable Power of Attorney for Health Care is probably best. It covers all situations when you can't speak for yourself, not just decisions about life-sustaining treatment. It gives everyone the best legal protection. Your physicians are also required to follow your agent's instructions or to transfer your care to another physician who will. If you don't have someone you want to name as your agent, there are other choices. But first let's talk about the Durable Power of Attorney for Health Care.

Do I need a special form for this Durable Power of Attorney for Health Care?

Yes. You can ask your physician, nurse, or social worker about the form. The California Medical Association has printed forms that meet the statutory requirements. You can get one from them at P.O. Box 7690, San Francisco, CA 94120-7690, or by calling (415) 882-5157. You can also get this form from California Health Decisions, Suite 400, 500 South Main St., Orange, CA 92668, (714) 647-4920. There is a small charge for this form from either group. Write or call first to find out the cost. Many stationary stores also carry forms. Be sure to get a Durable Power of Attorney for Health Care, not a plain Durable Power of Attorney. Lawyers can also prepare a Durable Power of Attorney for Health Care for you.

Is the form hard to fill out? Do I need a lawyer to help?

The form is usually about four pages. Some versions are longer or shorter. All the forms tell you how to fill them out. You can talk with your lawyer if you think that will be helpful, but you don't have to.

You will have to think about some things before you can fill out the form. First you need to think about when you would or wouldn't want medical treatment. Next, you need to talk to your family and your doctor. Then you need to decide if you have someone you want to make decisions for you if you can't make them yourself. This "agent" is sometimes called an "attorney-in-fact" (not an attorney-at-law), which is why the form is called the Durable Power of Attorney for Health Care. It is called "durable" because, unlike an ordinary power of attorney, it doesn't lose its effect when you become unable to make your own decisions. Indeed, the Durable Power of Attorney for Health Care only comes into effect when you can't speak for yourself. Until that time, your physicians will talk with you directly about your treatment choices even if you have appointed an agent.



HEALTH NET®
California's Health Plan

Issue Date 05-03-00

Group Name
MAINSTREAM UNIVERSAL
Member Name
REINA DELAHOUSSAYE
Member ID # **603-285-885-10**

Enrollment Date:
07-01-98
DOB **12-29-86**
Group #
0005900

Health Net Member Services, 24 Hours HPC 352
Member Inquiries and Provider Inquiries (800) 675-6110
Pharmacy Claims processed by: MedImpact Bin #:
Pharmacy Help Desk (800) 673-4666 **003585**

July 7, 06

Pop: Jalil
Eff: 4/1/06

Avalon

Silvia
Feb 11, 08

PCP:

eff: 1/1/08 on Hold

NO eligibility 2/03

5) 329-9247



REQUEST FOR A REFILL OR NEW PRESCRIPTION

AUTO-FAX ELECTRONICALLY TRANSMITTED: 10-27-2017 12:33

PRESCRIBER:

Name:	MARIAN JALIL	From:	CVS/pharmacy
		Store #	9852
Address:	14350 WHITTIER BLVDSTE 200 WHITTIER, CA 906052148	Address:	11426 WASHINGTON BLVD. WHITTIER, CA 90606
Phone:	562-945-7671	Phone:	562-695-4474
Fax:	562-945-7485	Fax:	562-695-4623

[Orig. Prescriber:]

Patient expects to pick-up prescription at: 10-31-2017 at 12:33

FOR PATIENT:

Name: DELAHOUSSAYE, REINA A
 DOB: 12-29-1986
 Address: 8210 BROADWAY AVE
 WHITTIER, CA 906063525
 Phone: 562-842-5856

FOR ORIGINAL PRESCRIPTION:

CVS Rx# 820019 Date Last Filled: 10-01-2017
 Medication: METFORMIN HCL 1,000 MG TABLET
 Qty. Prescribed: 180.0 EA One Hundred Eighty
 Prescribed Refills: 0
 Date Written: 08-05-2017
 SIG: TAKE 1 TABLET BY MOUTH TWICE A DAY

Pharmacy Comments:

This Prescription is valid only if transmitted by means of a facsimile machine

PRESCRIBER ACTION REQUIRED:

- Authorized this time plus _____ additional refills
 Not Authorized

Prescriber Comments:

Prescriber's Name (Printed): _____	Prescriber's DEA # _____
Transmitted by: _____ (KS/TX ONLY)	DPS # / Oral Code _____ (TX/HI ONLY)
Prescriber's Signature: _____	Date: _____
Massachusetts Only: Interchange is mandated unless Practitioner writes the words "No Substitution"	
The information contained in this electronic message as well as any attachments to this message are intended for the exclusive use of the intended recipient and may contain confidential or privileged information. If you are not the intended recipient, please destroy all copies of this message as well as its attachments and advise the sender immediately.	
FOR CVS USE ONLY:	SRX1 29000000002805280091

REQUEST FOR A REFILL OR NEW PRESCRIPTION

Reyne

Marian Jalil, MD, Inc.

Patient Progress Note

Patient Name: Reyne DeLoach DOS: 8-10 DOB: 12/29/86 AGE: 29 Sex: M/F

Allergies:

CC:

Flu Sinus Surgery

HPI:

WT: 72 HT: 6'0 BP: 114/78 TEMP: 91 P: / R: /
BMI: / Date & Results of Most Recent: HbA1c: / LDL: / See DM FlowsheetSystems Examined: (check)

- N Ab
- Gen. App
 - Skin
 - Eyes
 - Ears
 - Nose
 - Throat
 - Neck

- N Ab
- Heart
 - Chest / Lungs
 - Breast
 - Abdomen
 - Vaginal / Cervix
 - Bimanual
 - Rectal

- N Ab
- GU / Prostate
 - Back
 - Extremities
 - Pulses
 - Neuro
 - See Foot Exam Form

Incision healed

Diagnosis

Status

Plan

<u>JDM</u>	<u>ccc</u>	
<u>Post op spine decom press</u>		
<u>Mild deb</u>		

Patient Education: (check)

- Advance Directive
 - Diabetes
 - Diet
 - ETOH
 - Exercise
 - STD
 - Wound Care
 - DM Pocket Card
 - Reduce Fall Risks
 - Bladder Control
 - Mental Status
- DM Patient Action Plan
 - Safety
 - Seat Belt
 - Self Breast Exam
 - Self Testicle Exam
 - Stress Management
 - Smoking / Tobacco Cessation
 - Medication Side Effects
 - Functional Status
 - Pain Assessment
 - Medication Review

Order: (check)

- Basic Metabolic Panel
- Complex Metabolic Panel
- Lipid Panel
- Microalbumin Urine
- Other:

 HbA1c CBC Complete* Urinalysis Pneumonia /

Flu Vaccine

*Diagnosis must support need for testing

Referrals:

- DM Mgmt. Class (Health ED)
- DM Retinal Exam

n Visit:

Days (if not well):

Weeks/Months:

Marian Jalil, MD / Michael Yu Wang, PA



76020042-7 8945318-3

05th
MARIAH JALIL, M.D.

14350 WHITTIER BLVD STE 200
WHITTIER, CA 90605-2148

TELEPHONE 562-945-7671

DID YOU KNOW

Patient Service Center location
and appointment scheduling
information is on the back.

Each sample should be labeled with
at least two patient identifiers
at time of collection.

ICD Diagnosis Codes are Mandatory.
Fill in the applicable fields below.

DATE COLLECTED	TIME	<input type="checkbox"/> AM	TOTAL VOL/HRS.	<input type="checkbox"/> Fasting
	:	<input type="checkbox"/> PM	ML HR	<input type="checkbox"/> Non Fasting

NPI/UPIN ORDERING/SUPERVISING PHYSICIAN AND/OR PAYORS (MUST BE INDICATED)

() 1801897103 JALIL, MARIAH

() PBHP PRESBYTER

<input type="checkbox"/> ADDIT'L PHYS.: Dr.	NPI/UPIN	
NON-PHYSICIAN PROVIDER:	NAME	I.D.#
<input type="checkbox"/> Fax Results to: ()		
Send Duplicate Report to:	Client # OR NAME:	
ADDRESS:		
CITY: STATE ZIP		

PANEL COMPONENTS ON BACK
ORGAN / DISEASE PANELS

- 34392 Electrolyte Panel S
- 10256 Hepatic Function Panel S
- 10165 Basic Metabolic Panel S
- 10231 Comp Metabolic Panel S
- B7600 Lipid Panel (Fasting) S
- B14852 Lipid Panel w/Reflex D-LDL S
- @20210 Obstetric Panel w/Reflex Y,L,S
- @10306 Hepatitis Panel, Acute w/Reflex S
- 10314 Renal Functional Panel S

HEMATOLOGY

- @510 Hemoglobin L
- @509 Hematocrit L
- @1759 CBC (Hgb, Hct, RBC, WBC, Plt) L
- @6399 CBC w/Diff (Hgb, Hct, RBC, WBC, Plt, Diff) L
- B8847 PT with INR B
- @763 PTT, Activated B

OTHER TESTS

- 7788 ABO Group & Rh Type Y
- @237 APFTumor Marker S
- 223 Albumin S
- 234 Alkaline Phosphatase S
- 823 ALT S
- 243 Amylase S
- 249 ANA w/Reflex Titer S
- 795 Antibody Scr, RBC w/Reflex ID Y
- 822 AST S
- 285 Bilirubin, Direct S
- 287 Bilirubin, Total S

- 4420 C-Reactive Protein (CRP) S
- @29493 CA 27.29 S
- @29256 CA 125 S
- 303 Calcium S
- 11173 CCP Ab IgG S
- B978 CEA S
- B334 Cholesterol, Total S
- 374 CK, Total S
- 375 Creatinine S
- 402 DHEA Sulfate, Immunoassay S
- B2933 LDL Cholesterol, Direct S
- 4021 Estradiol S
- @457 Ferritin S
- 466 Folic Acid S
- 470 FSH S
- B482 GGT S
- 8477 Glucose, Gestational Screen (50g), 135 cutoff GY
- 19833 Glucose, Gestational Screen (50g), 140 cutoff GY
- B484 Glucose, Plasma GY
- B483 Glucose, Serum S
- 8435 hCG, Serum, Qual S
- B8396 hCG, Serum, Quant S
- B496 Hemoglobin A1c L
- B16802 Hemoglobin A1c w/eAG L
- 499 Hep B Surface Ab Qual S
- 498 Hep B Surface Ag w/Reflex Confirm S
- 8472 Hep C Antibody w/Reflex to Quant S
- 91431 HIV-1/2 AG/AB, 4th w/Reflex S
- 31789 Homocysteine S
- 10124 hs CRP S
- 561 Insulin S
- 549 Immunofixation (IFE) S
- @7573 Iron,TIBC, % Sat S

PRIMARY INSURANCE

RELATIONSHIP TO INSURED	<input type="checkbox"/> SELF	<input type="checkbox"/> SPOUSE	<input type="checkbox"/> DEPENDENT
INSURANCE COMPANY NAME / IPA NAME			
INSURANCE COMPANY ADDRESS		CITY	ST ZIP
INSURANCE ID #		GROUP # / DATE OF INJURY	
MEDICARE #		MEDI-CAL #	
EMPLOYER NAME / EMPLOYER #			

ABN required for tests with these symbols

Medicare Limited Coverage Tests @= May not be covered for the reported diagnosis.
F= Has prescribed frequency rules for coverage.
&= A test or service performed with research/experimental kit.
B= Has both diagnosis and frequency-related coverage limitations.

Provide signed ABN when necessary

ICD Codes (enter all that apply)

E11.9 K53.83

4571 <input type="checkbox"/> Iron S	6448 <input type="checkbox"/> UA, Dipstick Only U
593 <input type="checkbox"/> LDH S	7909 <input type="checkbox"/> UA, Dipstick w/Reflex Microscopic U
599 <input type="checkbox"/> Lead, Blood TN	5463 <input type="checkbox"/> UA, Complete (Dipstick & Microscopic) U
615 <input type="checkbox"/> LH S	@3020 <input type="checkbox"/> UA, Complete, w/Reflex Culture 1
606 <input type="checkbox"/> Lipase S	294 <input type="checkbox"/> Urea Nitrogen (BUN) S
6646 <input type="checkbox"/> Lyme Disease Ab w/Reflex to Blot (IgG, IgM) S	905 <input type="checkbox"/> Uric Acid S
622 <input type="checkbox"/> Magnesium S	916 <input type="checkbox"/> Valproic Acid SR
6517 <input type="checkbox"/> Microalbumin, Random Urine w/Creat	4439 <input type="checkbox"/> Varicella-Zoster Virus Ab (IgG) S
F11290 <input type="checkbox"/> Occult Blood, Feces - FIT InSure® [®] 1	7065 <input type="checkbox"/> Vitamin B12/Folic Acid S
718 <input type="checkbox"/> Phosphorus S	927 <input type="checkbox"/> Vitamin B12 S
733 <input type="checkbox"/> Potassium S	17306 <input type="checkbox"/> Vitamin D, 25-Hydroxy, Total, Immunoassay S
745 <input type="checkbox"/> Progesterone S	91935 <input type="checkbox"/> Vitamin D (QuestAssured™ for Infants) SR
746 <input type="checkbox"/> Prolactin S	25-Hydroxyvitamin D, LC/MS/MS (3 Sys)
B5363 <input type="checkbox"/> PSA, Total L	MICROBIOLOGY
793 <input type="checkbox"/> Reticulocyte Count, Automated S	Source (Required) _____
4418 <input type="checkbox"/> Rheumatoid Factor S	4550 <input type="checkbox"/> Culture, Aerobic Bacteria*
799 <input type="checkbox"/> RPR (Monitoring) w/Reflex Titer S	4446 <input type="checkbox"/> Culture, Aerobic & Anaerobic*
36126 <input type="checkbox"/> RPR (DX) w/Reflex Confirm S	4485 <input type="checkbox"/> Culture, Group A Strep*
802 <input type="checkbox"/> Rubella IgG S	5617 <input type="checkbox"/> Culture, Group B Strep*
809 <input type="checkbox"/> Sed Rate by Mod West L	4558 <input type="checkbox"/> Culture, Genital*
15983 <input type="checkbox"/> Testosterone, Total, LC/MS/MS SR	394 <input type="checkbox"/> Culture, Throat*
873 <input type="checkbox"/> Testosterone, Total, Male SR	@395 <input type="checkbox"/> Culture, Urine, Routine* (Inc. Indwelling Cath)
5081 <input type="checkbox"/> Thyroid Peroxidase Antibodies (TPO) S	Amplified Specimen Type (Optima)
B896 <input type="checkbox"/> Triglycerides S	<input type="checkbox"/> Endovaginal <input type="checkbox"/> Urethral <input type="checkbox"/> Urine
B899 <input type="checkbox"/> TSH S	11363 <input type="checkbox"/> Chlamydia & N. gonorrhoeae RNA, TMA
B36127 <input type="checkbox"/> TSH w/Reflex T4, Free S	Stool Pathogens (Salmon/Shig/Campy,
34429 <input type="checkbox"/> T3, Free S	10108 <input type="checkbox"/> Culture, Stool, Shiga toxins w/Reflex)*
859 <input type="checkbox"/> T3, Total S	34838 <input type="checkbox"/> H. pylori Ag, EIA Stool
B861 <input type="checkbox"/> T3 Uptake S	14839 <input type="checkbox"/> H. pylori Urea Breath Test
B867 <input type="checkbox"/> T4 (Thyroxine), Total S	* 681 <input type="checkbox"/> O & P w/Permanent Stain
B866 <input type="checkbox"/> T4 (Thyroxine), Free S	HB

* Additional charge for ID and Susceptibilities

Reflex tests are performed at an additional charge.

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ADDITIONAL TESTS: (INCLUDE COMPLETE TEST NAME AND ORDER CODE)

HRANC 8181

COMMENTS, CLINICAL INFORMATION:

TOTAL TESTS ORDERED

Physician Signature

Many payers (including Medicare and Medicaid) have medical necessity requirements. You should only order those tests which are medically necessary for the diagnosis and treatment of the patient.

REOLGLA

76020042 8945318 894531

NAME: 76020042 8945318 894531

All samples to be shipped ambient, unless otherwise specified.
3020 UA, Complete Reflex to Culture, REQUIRES 2 specimens, Yellow Cap Urine Vial with Blue Fill Line and a Gray top urine transport tube

Specimen Key:	B	= Blue top tube	S	= Serum or Spun Barrier tube (SST)
	GY	= Gray top tube	TN	= Tan top tube (EDTA)
	HB	= Human breath	U	= Yellow top (Screw Cap Vial), Blue Fill Line, Preservative tube
	L	= Lavender top tube	Y	= Yellow top tube
	SR	= Serum from a Red top tube	1	= Consult the Specimen Collection Guide for Special Instructions

All reflex tests will be performed at an additional charge.

Test Code	Profile Components	34392 Electrolyte Panel	10256 Hepatic Function Panel	10165 Basic Metabolic Panel	10231 Comp Metabolic Panel	7600 Lipid Panel	14852 Lipid Panel w/Reflex d-LDL	20210 Obstetric Panel w/Reflex	10306 Hepatitis Panel Acute w/Reflex	10314 Renal Functional Panel
836	Sodium	X		X	X					X
733	Potassium	X		X	X					X
330	Chloride	X		X	X					X
310	Carbon Dioxide	X		X	X					X
223	Albumin		X		X					X
285	Bilirubin, Direct		X							
287	Bilirubin, Total		X		X					
234	Alkaline Phosphatase		X		X					
822	AST		X		X					
823	ALT		X		X					
754	Protein, Total		X		X					
303	Calcium			X	X					X
483	Glucose, Serum			X	X					X
294	Urea Nitrogen			X	X					X
375	Creatinine			X	X					X
334	Cholesterol, Total					X	X			
896	Triglycerides					X	X			
608	HDL					X	X			
718	Phosphorus									X
8293	d-LDL when Trig >400						X			
7788	ABO/Rh							X		
795	Antibody Scr RBC w/reflex							X		
6399	CBC							X		
36126	RPR w/reflex confirm							X		
498	HBsAg w/reflex confirm							X	X	
802	Rubella IgG Ab							X		
8472	Hep C Antibody w/Reflex to Quant								X	
512	HA Ab IgM								X	
4848	HBcAb IgM								X	

Patients: Minimize your wait time by scheduling an appointment at a convenient Patient Service Center.

To find a location and make an appointment visit us at QuestDiagnostics.com/appointment or call 888-277-8772 or simply download our mobile app. at QuestDiagnostics.com/mobile



Marian Jalil, MD, Inc.

Patient Progress Note

Patient Name: Della Housley, Debra DOS: 1/29/17 DOB: 12/29/96 AGE: 29 Sex: M/F

Allergies:

CC:

Right Sciatic Pain

HPI:

WT: 242 HT: 6'0 BP: 128/90 TEMP: 90 P: 13/15 R: N/A
BMI: 33 Date & Results of Most Recent: HbA1c: 12.6 LDL: N/A See DM FlowsheetSystems Examined: (check)

N	Ab	N	Ab	N	Ab
<input type="checkbox"/>	□ Gen. App	<input type="checkbox"/>	□ Heart	<input type="checkbox"/>	□ GU / Prostate
<input type="checkbox"/>	□ Skin	<input type="checkbox"/>	□ Chest / Lungs	<input type="checkbox"/>	□ Back
<input type="checkbox"/>	□ Eyes	<input type="checkbox"/>	□ Breast	<input type="checkbox"/>	□ Extremities
<input type="checkbox"/>	□ Ears	<input type="checkbox"/>	□ Abdomen	<input type="checkbox"/>	□ Pulses
<input type="checkbox"/>	□ Nose	<input type="checkbox"/>	□ Vaginal / Cervix	<input type="checkbox"/>	□ Neuro
<input type="checkbox"/>	□ Throat	<input type="checkbox"/>	□ Bimanual	<input type="checkbox"/>	□ See Foot Exam Form
<input type="checkbox"/>	□ Neck	<input type="checkbox"/>	□ Rectal		

Diagnosis

Status

Plan

<u>Right Lumbar Strain</u>		
<u>CLE Radicular</u>		
<u>PDDM</u>	<u>OOC</u>	

Patient Education: (check)

- | | |
|--|--|
| <input type="checkbox"/> Advance Directive | <input type="checkbox"/> DM Patient Action Plan |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Safety |
| <input type="checkbox"/> Diet | <input type="checkbox"/> Seat Belt |
| <input type="checkbox"/> ETOH | <input type="checkbox"/> Self Breast Exam |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Self Testicle Exam |
| <input type="checkbox"/> STD | <input type="checkbox"/> Stress Management |
| <input type="checkbox"/> Wound Care | <input type="checkbox"/> Smoking / Tobacco Cessation |
| <input type="checkbox"/> DM Pocket Card | <input type="checkbox"/> Medication Side Effects |
| <input type="checkbox"/> Reduce Fall Risks | <input type="checkbox"/> Functional Status |
| <input type="checkbox"/> Bladder Control | <input type="checkbox"/> Pain Assessment |
| <input type="checkbox"/> Mental Status | <input type="checkbox"/> Medication Review |

Order: (check)

- | | |
|---|---|
| <input type="checkbox"/> Basic Metabolic Panel | <input checked="" type="checkbox"/> HbA1c |
| <input checked="" type="checkbox"/> Complex Metabolic Panel | <input type="checkbox"/> CBC Complete* |
| <input type="checkbox"/> Lipid Panel | <input type="checkbox"/> Urinalysis |
| <input type="checkbox"/> Microalbumin Urine | <input type="checkbox"/> Pneumonia / |
| *Diagnosis must support need for testing | |
| <input type="checkbox"/> Other: | Flu Vaccine |

Referrals: DM Mgmt. Class (Health ED)
 DM Retinal Exam

Return Visit:

Days (if not well):

Weeks/Months:

Marian Jalil, MD / Michael Yu Wang, PA

Patient Progress Note

Patient Name: Delphosay, Reina

DOS: 1/19/17 DOB: 12/29/86 AGE: 29

Sex: M/F

Allergies:

C:

Bad hip pain

(R) hip pain → (R) leg

HPI:

WT: 245 HT: 6'0 BP: 118/72 TEMP: 90 P: R:

BMI: 33 Date & Results of Most Recent: HbA1c: 126 1/3/15 LDL: N/A 13/15 □ See DM Flowsheet

GATE LMA

Systems Examined: (check)

- | | |
|-------------------------------------|------------|
| N | Ab |
| <input checked="" type="checkbox"/> | □ Gen. App |
| <input type="checkbox"/> | □ Skin |
| <input type="checkbox"/> | □ Eyes |
| <input type="checkbox"/> | □ Ears |
| <input type="checkbox"/> | □ Nose |
| <input type="checkbox"/> | □ Throat |
| <input checked="" type="checkbox"/> | □ Neck |

- | | |
|-------------------------------------|--------------------|
| N | Ab |
| <input type="checkbox"/> | □ Heart |
| <input type="checkbox"/> | □ Chest / Lungs |
| <input checked="" type="checkbox"/> | □ Breast |
| <input type="checkbox"/> | □ Abdomen |
| <input type="checkbox"/> | □ Vaginal / Cervix |
| <input type="checkbox"/> | □ Bimanual |
| <input type="checkbox"/> | □ Rectal |

- | | |
|--------------------------|----------------------|
| N | Ab |
| <input type="checkbox"/> | □ GU / Prostate |
| <input type="checkbox"/> | □ Back |
| <input type="checkbox"/> | □ Extremities |
| <input type="checkbox"/> | □ Pulses |
| <input type="checkbox"/> | □ Neuro |
| <input type="checkbox"/> | □ See Foot Exam Form |

Diagnosis

Status

Plan

(R) hip pain, sacroiliac joint dysfunction		Robaxin 750mg po qd, prn. (PT eval)
Obesity	liver	Soma 250mg po qd, prn
DM	control	
Hypertension	as needed	

Patient Education: (check)

- | | |
|-------------------------------------|-------------------|
| <input checked="" type="checkbox"/> | Advance Directive |
| <input checked="" type="checkbox"/> | Diabetes |
| <input checked="" type="checkbox"/> | Diet |
| <input checked="" type="checkbox"/> | ETOH |
| <input type="checkbox"/> | Exercise |
| <input type="checkbox"/> | STD |
| <input type="checkbox"/> | Wound Care |
| <input type="checkbox"/> | DM Pocket Card |
| <input type="checkbox"/> | Reduce Fall Risks |
| <input type="checkbox"/> | Bladder Control |
| <input type="checkbox"/> | Mental Status |

- | | |
|-------------------------------------|-----------------------------|
| <input type="checkbox"/> | DM Patient Action Plan |
| <input type="checkbox"/> | Safety |
| <input type="checkbox"/> | Seat Belt |
| <input type="checkbox"/> | Self Breast Exam |
| <input type="checkbox"/> | Self Testicle Exam |
| <input checked="" type="checkbox"/> | Stress Management |
| <input type="checkbox"/> | Smoking / Tobacco Cessation |
| <input type="checkbox"/> | Medication Side Effects |
| <input type="checkbox"/> | Functional Status |
| <input type="checkbox"/> | Pain Assessment |
| <input type="checkbox"/> | Medication Review |

Order: (check)

- | | | | |
|--------------------------|-------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | Basic Metabolic Panel | <input type="checkbox"/> | HbA1c |
| <input type="checkbox"/> | Complex Metabolic Panel | <input type="checkbox"/> | CBC Complete* |
| <input type="checkbox"/> | Lipid Panel | <input type="checkbox"/> | Urinalysis |
| <input type="checkbox"/> | Microalbumin Urine | <input type="checkbox"/> | Pneumonia / Flu Vaccine |
- *Diagnosis must support need for testing
- Other:

Referrals: DM Mgmt. Class (Health ED)
 DM Retinal Exam

Return Visit:

Days (if not well):

Weeks/Months:

Marian Jalil, MD / Michael Yu Wang, PA

Certificate to return to work

Name Leina Delahoussaye

has been under my care from 7/20/10 to 7/20/10

and will be able to return to work on 7/20/10

Nature of illness or injury _____

Restrictions

Light work

Comments _____

Marian Jalil, M.D., Inc.
14350 E. Whittier Blvd., Suite 200
WHITTIER, CALIFORNIA 90605

Phone

(562) 945-7671

Date

7/20/10

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E0481 5/01

FINAL

PIH HEALTH HOSPITAL - WHITTIER

12401 East Washington Blvd -Whittier, CA 90602 - (562) 698-0811

EMERGENCY DEPARTMENT VISIT**CHIEF COMPLAINT:** Hip pain.

HISTORY OF PRESENT ILLNESS: The patient is a 29-year-old female, past medical history of diabetes who presents to the ED for the above complaint on July 15, 2016. The patient states that she started experiencing right hip pain 2 months ago when she felt that she pulled a hamstring and/or injured her hip while at the gym using a 30 pound weight. She was seen by her primary care physician approximately one month ago where she had an x-ray done and no fracture was found. She was prescribed ibuprofen which she has been taking and she stated the pain started getting better up until 2 days ago. The patient states that she was at work 2 days ago moving heavy kegs when she started experiencing pain again to her right hip area which has persisted despite the use of ibuprofen at home. She states that the pain gets worse when she sits down or lays down and mildly improved when she is standing. She describes the pain as a Charley horse type of pain that goes down to her leg. She denies any low back pain. She denies any saddle anesthesia or paresthesias. She last took 1600 mg of ibuprofen at 9 p.m. last night and a Tylenol #3 tablet at 3:00 this morning which she states dulled the pain; however, her pain is still present.

PRIMARY CARE PHYSICIAN: Dr. Marian Jalil.**PAST MEDICAL HISTORY:** Diabetes.**MEDICATIONS:** None.**ALLERGIES:** No known allergies.**PAST SURGICAL HISTORY:** Negative.**SOCIAL HISTORY:** Negative. Last menstrual period was completed 2 days ago.**REVIEW OF SYSTEMS:** As in HPI, otherwise, all systems are negative.

PHYSICAL EXAMINATION: VITAL SIGNS: Blood pressure 172/97, heart rate 76 beats per minute, respiratory rate 20 per minute, temperature 98 degrees Fahrenheit. **GENERAL:** Well-

Patient Name: DELAHOUSSAYE, REINA **DOB:** 12/29/1986**Physician:** CINTHYA VASQUEZ, DNP**MR Number:** 361384**EMERGENCY DEPARTMENT VISIT****Visit Date:** 07/15/2016

Page 1 of 3

COPY FOR MARIAN JALIL MD

FINAL

PIH HEALTH HOSPITAL - WHITTIER

12401 East Washington Blvd -Whittier, CA 90602 - (562) 698-0811

nourished, well-developed female in no acute distress. SKIN: Warm, dry and intact with no rashes, no ecchymosis. MUSCULOSKELETAL: There is mild pain to the right buttock area near the sacroiliac joint. There is limited extension and flexion of the hip secondary to pain. She denies any radiation of the pain down her leg upon pressure applied to the tender area. NEUROLOGIC: Awake, alert and oriented x4, no focal neuro deficits and patient is cooperative.

EMERGENCY DEPARTMENT COURSE: The patient's pain is highly unlikely of fracture, given that she had an x-ray done 1 month ago with her primary care physician, which showed no fracture. I discussed with the patient the likelihood that she may have some sacroiliac joint dysfunction as well as a possibility with mild to minimal sciatic nerve inflammation. She was medicated with Robaxin 750 mg orally while she was here in the ER, which she tolerated well and she is comfortable being discharged home at this time.

IMPRESSION: Hip pain with possible sacroiliac joint dysfunction.

PLAN: The patient is discharged home with a prescription for Robaxin to take as needed. She is also given a prescription for Norco 5/325 mg as needed for pain. She was advised to follow up with her primary care physician for possible physical therapy and/or orthopedic referral for further outpatient evaluation and management. The patient verbally understands her instructions and is discharged home in stable condition.

Dictation electronically signed by
CINTHYA VASQUEZ, DNP on 07/19/2016 13:26:22

CINTHYA VASQUEZ, DNP

Dictation electronically signed by
KEVIN ANDRUSS, MD on 07/20/2016 08:47:06

ATTENDING:

KEVIN ANDRUSS, MD

CV/cn
D: 07/15/2016 07:03:06
T: 07/15/2016 14:16:41
Job #: 10627256

Patient Name: DELAHOUSSAYE, REINA

DOB: 12/29/1986

Physician: **CINTHYA VASQUEZ, DNP**

MR Number: 361384

EMERGENCY DEPARTMENT VISIT

Visit Date: 07/15/2016

Page 2 of 3

COPY FOR MARIAN JALIL MD

FACSIMILE TRANSMITTAL COVER SHEET

CONFIDENTIAL HEALTH INFORMATION ENCLOSED

Health information is personal and sensitive information related to a person's healthcare. It is being faxed to you after appropriate authorization from the patient or under circumstances that do not require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law.

Date: 7/20/2016Time: 8:48 AMTotal number of pages: 4

(including cover sheet)

TO: MARIAN JALIL MD9457485

Fax Number

FROM: Medical Transcription Department(562) 789-4410

Name of Sender

Fax Number

(562) 698-0811

Telephone Number

x 12650

EXT

PIH HEALTH HOSPITAL
12401 Washington Blvd.
Whittier, CA 90602

(562) 696-9267

TDD telephone Number



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VERIFICATION OF RECEIPT: Please contact the sender listed above to verify receipt of this material.

Thank you

FINAL

PIH HEALTH HOSPITAL - WHITTIER

12401 East Washington Blvd -Whittier, CA 90602 - (562) 698-0811

Acc#: 60021649
Conf#: 284266

Patient Name: DELAHOUSSAYE, REINA **DOB:** 12/29/1986

Physician: CINTHYA VASQUEZ, DNP **MR Number:** 361384
EMERGENCY DEPARTMENT VISIT **Visit Date:** 07/15/2016
Page 3 of 3

COPY FOR MARIAN JALIL MD

Patient Progress Note

Patient Name: Delshouse & Reno DOS: 7/20/16 DOB: 12/29/66 AGE: 29 Sex: M/F

Allergies:

CC: Here for r/r D. C/o Pain Hip.

HPI: CT (R) hip pain. went to PZ ER, pain relief given

WT: 248 HT: 6'0" BP: 120/74 TEMP: P: 77 R:

BMI: 33 Date & Results of Most Recent HbA1c: 17.10/31/15 LDL: 170 mg/dL See DM Flowsheet

Systems Examined: (check)

- Ab
 Gen. App
 Skin
 Eyes
 Ears
 Nose
 Throat
 Neck

- N Ab
 Heart
 Chest / Lungs
 Breast
 Abdomen
 Vaginal / Cervix
 Bimanual
 Rectal

- N Ab
 GU / Prostate
 Back
 Extremities (R) hip pain
 Pulses
 Neuro
 See Foot Exam Form

Diagnosis

Status

Plan

(R) hip pain		D. Longmire Orthopedic referral
SP (R) hip X-ray - normal		Dr. Purnell Chiropractor referral
DM	out of control	skin management Dr. Haferz on weekly
Obesity	↓ weight.	
Hyperglycemia		

Patient Education: (check)

- Advance Directive
 Diabetes
 Diet
 ETOH
 Exercise
 STD
 Wound Care
 DM Pocket Card
 Reduce Fall Risks
 Bladder Control
 Mental Status
- DM Patient Action Plan
 Safety
 Seat Belt
 Self Breast Exam
 Self Testicle Exam
 Stress Management
 Smoking / Tobacco Cessation
 Medication Side Effects
 Functional Status
 Pain Assessment
 Medication Review

Order: (check)

- Basic Metabolic Panel
 Complex Metabolic Panel
 Lipid Panel
 Microalbumin Urine
 CBC Complete*
 Urinalysis
 Pneumonia / Flu Vaccine

*Diagnosis must support need for testing

 Other:Referrals: DM Mgmt. Class (Health ED)
 DM Retinal Exam

Return Visit: Days (if not well): 2 Weeks/Months:

M W

Marian Jalil, MD / Michael Yu Wang, PA

Marian Jalil, MD, Inc.

Patient Progress Note

Patient Name: De la hoyang Dens DOS: 7/1/12 DOB: AGE: Sex: M/F

Allergies:

CC:

HPI:

WT:	HT:	BP:	TEMP:	P:	R:
BMI:	Date & Results of Most Recent: HbA1c:			/	LDL: / <input type="checkbox"/> See DM Flowsheet

Systems Examined: (check)

N	Ab	N	Ab	N	Ab
<input type="checkbox"/>	□ Gen. App	<input type="checkbox"/>	□ Heart	<input type="checkbox"/>	□ GU / Prostate
<input type="checkbox"/>	□ Skin	<input type="checkbox"/>	□ Chest / Lungs	<input type="checkbox"/>	□ Back
<input type="checkbox"/>	□ Eyes	<input type="checkbox"/>	□ Breast	<input type="checkbox"/>	□ Extremities
<input type="checkbox"/>	□ Ears	<input type="checkbox"/>	□ Abdomen	<input type="checkbox"/>	□ Pulses
<input type="checkbox"/>	□ Nose	<input type="checkbox"/>	□ Vaginal / Cervix	<input type="checkbox"/>	□ Neuro
<input type="checkbox"/>	□ Throat	<input type="checkbox"/>	□ Bimanual	<input type="checkbox"/>	□ See Foot Exam Form
<input type="checkbox"/>	□ Neck	<input type="checkbox"/>	□ Rectal		

Diagnosis	Status	Plan

Patient Education: (check)

- Advance Directive
- Diabetes
- Diet
- ETOH
- Exercise
- STD
- Wound Care
- DM Pocket Card
- Reduce Fall Risks
- Bladder Control
- Mental Status

- DM Patient Action Plans
- Safety
- Seat Belt
- Self Breast Exam
- Self Testicle Exam
- Stress Management
- Smoking / Tobacco Cessation
- Medication Side Effects
- Functional Status
- Pain Assessment
- Medication Review

Order: (check)

- Basic Metabolic Panel
- Complex Metabolic Panel
- Lipid Panel
- Microalbumin Urine
- CBC Complete*
- Urinalysis
- Pneumonia / Flu Vaccine
- Other:

Referrals: DM Mgmt. Class (Health ED)
 DM Retinal Exam

Return Visit: Days (if not well): Weeks/Months:

Marian Jalil, MD / Michael Yu Wang, PA

est
noscis™



42-7 4466535-6

IAN JALIL, M.D.

1350 WHITTIER BLVD STE 200
WHITTIER, CA 90605-2148

562-945-7671

ICTED	TIME	<input type="checkbox"/> AM	TOTAL VOL/HRS:	<input type="checkbox"/> Fasting
	:	<input type="checkbox"/> PM	ML HR	<input type="checkbox"/> Non Fasting

ORDERING/SUPERVISING PHYSICIAN AND/OR PAYORS (MUST BE INDICATED)

1801897103 JALIL, MARIAM

DID YOU KNOW

Patient Service Center location
and appointment scheduling
information is on the back.

Each sample should be labeled
with at least two patient identifiers
at time of collection.

BILL TO:
 MY ACCOUNT
 PATIENT
 MEDICARE
 RAILROAD MEDICARE
 Medi-Cal
 Lab Card/Select
 OTHER INSURANCE

PRINT PATIENT NAME (LAST, FIRST, MIDDLE)

PATIENT ID / REGISTRATION #

DATE M M D YEAR
OF BIRTH 10/29/1986 SEX

ROOM # LAB REFERENCE #

PATIENT SOCIAL SECURITY #

PATIENT PHONE # ()

PATIENT STREET ADDRESS

APT. # KEY #

CITY

STATE ZIP

PRINT NAME OF INSURED/RESPONSIBLE PARTY (LAST, FIRST, MIDDLE) - IF OTHER THAN PATIENT

INSURED ADDRESS

CITY

STATE ZIP

RELATIONSHIP TO INSURED SELF SPOUSE DEPENDENT

INSURANCE COMPANY NAME / IPA NAME

INSURANCE COMPANY ADDRESS CITY ST ZIP

INSURANCE ID #

GROUP # / DATE OF INJURY

MEDICARE #

MEDI-CAL #

EMPLOYER NAME / EMPLOYER #

Medicare = May not be covered for the reported diagnosis.
Limited F = Has prescribed frequency rules for coverage.
Coverage & = A test or service performed with research/experimental kit.
Tests B = Has both diagnosis and frequency-related coverage limitations.

Provide signed
ABN when
necessary

ICD Codes (enter all that apply)

R73.09 N39.0 R94.0

PHYSICIAN NAME NPI/UPIN

PROVIDER I.D.#

Results to: ()

Client # OR NAME:

ADDRESS:

CITY: STATE ZIP

TEST COMPONENTS ON BACK

ORGAN / DISEASE PANELS

- Electrolyte Panel S
- Hepatic Function Panel S
- Basic Metabolic Panel S
- Comp Metabolic Panel S
- Lipid Panel (Fasting) S
- Lipid Panel w/Reflex LDL S
- Obstetric Panel w/Reflex Y,L,S
- Hepatitis Panel, Acute w/Reflex S
- Renal Functional Panel S

HEMATOLOGY

- Hemoglobin L
- Hematocrit L
- CBC (Hgb, Hct, RBC, WBC, Plt) L
- CBC w/Diff (Hgb, Hct, RBC, WBC, Plt, Diff) L
- PT with INR B
- PTT, Activated B

8435 HCG, TOTAL, RL

AIC 8181

7 CTS if mol

SH Thyroid 74044

OTHER TESTS

823	<input type="checkbox"/> ALT	S	@ 571	<input type="checkbox"/> Iron	S	15983	<input type="checkbox"/> Testosterone, Total, LC/MS/MS	SR
243	<input type="checkbox"/> Amylase	S	593	<input type="checkbox"/> LDH	S	873	<input type="checkbox"/> Testosterone, Total, Male	SR
249	<input type="checkbox"/> ANA w/Reflex Titer & Pattern	S	599	<input type="checkbox"/> Lead, Blood	TN	6448	<input type="checkbox"/> UA, Dipstick Only	U
822	<input type="checkbox"/> AST	S	622	<input type="checkbox"/> Magnesium	S	7909	<input type="checkbox"/> UA, Dipstick, w/Reflex Microscopic	U
4420	<input type="checkbox"/> C-Reactive Protein (CRP)	S	6517	<input type="checkbox"/> Microalbumin, Random Urine w/Creat		5463	<input type="checkbox"/> UA, Complete (Dipstick & Microscopic)	U
B 334	<input type="checkbox"/> Cholesterol, Total	S	Fecal Globin, Feces - FIT, InSure® ^{®1}	<input type="checkbox"/> Diagnostic		@ 3020	<input type="checkbox"/> UA, Complete, w/Reflex Culture	
374	<input type="checkbox"/> CK, Total	S	718	<input type="checkbox"/> Phosphorus	S	294	<input type="checkbox"/> Urea Nitrogen (BUN)	S
375	<input type="checkbox"/> Creatinine	S	B 5363	<input type="checkbox"/> PSA, Total	S	905	<input type="checkbox"/> Uric Acid	S
@ 457	<input type="checkbox"/> Ferritin	S	4418	<input type="checkbox"/> Rheumatoid Factor	S	927	<input type="checkbox"/> Vitamin B12	S
470	<input type="checkbox"/> FSH	S	799	<input type="checkbox"/> RPR (Monitoring) w/Reflex Titer	S	7065	<input type="checkbox"/> Vitamin B12/Folic Acid	S
B 482	<input type="checkbox"/> GGT	S	36126	<input type="checkbox"/> RPR (DX) w/Reflex Confirm	S	17306	<input type="checkbox"/> Vitamin D, 25-Hydroxy, Total, Immunoassay	S
8477	<input type="checkbox"/> Glucose Gestational Screen (50g)-135 Cutoff	GY	809	<input type="checkbox"/> Sed Rate by Mod West		MICROBIOLOGY		
B 483	<input type="checkbox"/> Glucose, Serum	S	B 899	<input type="checkbox"/> TSH	S	L Source (Required) _____		
B 836	<input type="checkbox"/> hCG, Serum, Quant	S	B 36127	<input type="checkbox"/> TSH w/Reflex T4, Free	S	4550	<input type="checkbox"/> Culture, Aerobic Bacteria*	
B 496	<input type="checkbox"/> Hemoglobin A1c	L	34429	<input type="checkbox"/> T3, Free	S	5617	<input type="checkbox"/> Culture, Group B Strep*	
498	<input type="checkbox"/> Hep B Surface Ag w/Reflex Confirm	S	859	<input type="checkbox"/> T3, Total	S	394	<input type="checkbox"/> Culture, Throat*	
8472	<input type="checkbox"/> Hep C Virus Ab	S	B 861	<input type="checkbox"/> T3 Uptake	S	@ 395	<input type="checkbox"/> Culture, Urine Routine*	
91431	<input type="checkbox"/> HIV-1/2 AG/AB, 4th w/Reflex	S	B 867	<input type="checkbox"/> T4 (Thyroxine), Total	S	Amplified Specimen Type (please check one)		
			B 866	<input type="checkbox"/> T4 (Thyroxine), Free	S	<input type="checkbox"/> Endocervical	<input type="checkbox"/> Urethral	<input type="checkbox"/> Urine
						11363	<input type="checkbox"/> Chlamydia & N. gonorrhoeae RNA, TMA	

TS: (MUST INCLUDE COMPLETE TEST NAME AND ORDER CODE. REFER TO DIRECTORY OF SERVICES.)

* Additional charge for ID/Susceptibility studies.
Reflex tests are performed at an additional charge.

ICAL INFORMATION:

TOTAL TESTS
ORDERED

REQSMCLA

76020042

76020042

76020042

4466535

4466535

4466535

NANE:

76020042

76020042

4466535

4466535

Many payers (including Medicare and Medicaid) have medical necessity requirements. You should only order those tests which are medically necessary for the diagnosis and treatment of the patient.

11/13/2017

All samples to be shipped ambient, unless otherwise specified.
 3020 UA, Complete Reflex to Culture REQS 2 specimens, Yellow Cap Urine Vial with Blue Fill Line and a Gray top urine transport tube

Specimen Key:	B = Blue top tube	HB = Human breast
	BX = Unopened Barrier tube	L = Lavender top tube
	FBP = Frozen Plasma Blue top tube	SR = Serum from a Red top tube
	FP = Frozen Plasma	S = Serum or Span Barrier tube (SST)
	FS = Frozen Serum	TN = Tan top tube (EDTA)
	GN = Green top tube (Sodium Heparin)	U = Yellow top (Screw Cap Vial), Blue Fill Line, Preservative tube
	GY = Gray top tube	Y = Yellow top tube

All reflex tests will be performed at an additional charge.

Test Code	Profile Components	34392 Electrolyte Panel	10256 Hepatic Function Panel	10165 Basic Metabolic Panel	10231 Comp Metabolic Panel	7600 Lipid Panel	14852 Lipid Panel w/Reflex d-LDL	20210 Obstetric Panel w/Reflex	10306 Hepatitis Panel Acute w/Reflex	10314 Renal Function Panel
836	Sodium	X		X	X					X
733	Potassium	X		X	X					X
330	Chloride	X		X	X					X
310	Carbon Dioxide	X		X	X					X
223	Albumin		X		X					X
285	Bilirubin, Direct		X							
287	Bilirubin, Total		X		X					
234	Alkaline Phosphatase		X		X					
822	AST		X		X					
823	ALT		X		X					
754	Protein, Total		X		X					
333	Calcium			X	X					X
483	Glucose, Serum			X	X					X
294	Urea Nitrogen			X	X					X
375	Creatinine			X	X					X
334	Cholesterol, Total					X	X			
896	Triglycerides					X	X			
608	HDL					X	X			
718	Phosphorus									X
8293	d-LDL when Trig >400						X			
7788	ABO/Rh								X	
795	Antibody Scr RBC w/reflex								X	
6399	CBC (includes Differential and Platelets)								X	
36126	RPR w/reflex confirm								X	
498	HBsAg w/reflex confirm							X	X	
802	Rubella IgG Ab							X		
8472	HC Ab									X
512	HA Ab IgM									X
4848	HBcAb IgM									X

Patients: Minimize your wait time by scheduling an appointment at convenient Patient Service Center.

To find a location and make an appointment visit us at QuestDiagnostics.com/appointment call 888-277-8772 or simply download our mobile app. at QuestDiagnostics.com/mobile



Marian Jalil, MD, Inc.

Patient Progress Note

Patient Name: De la Hozsey Reyno DOS: 6-15-16 DOB: 12/29/86 AGE: 29 Sex: M/F

Allergies:

CC: Injury RT hip at the gym.

HPI: 3 wks ago, (R) hip pain by use new equipment; J ROM.

WT: 246 HT: 6'0" BP: 118/98 TEMP: P: 84 R:

BMI: 33 Date & Results of Most Recent: HbA1c: 12.6/31/15 LDL: 170 See DM Flowsheet

Systems Examined: (check)

- Ab
 Gen. App
 Skin
 Eyes
 Ears
 Nose
 Throat
 Neck

- N Ab
 Heart
 Chest / Lungs
 Breast
 Abdomen
 Vaginal / Cervix
 Bimanual
 Rectal

- N Ab
 GU / Prostate
 Back
 Extremities (R) hip tender.
 Pulses
 Neuro
 See Foot Exam Form

Diagnosis

Status

Plan

(R) hip pain		(R) hip X-ray
DM	out of control	PT refine goals
Obesity		
Hyperglycemia		
PAP due.		(OB/GYN) no foul for PAP + BC

Patient Education: (check)

- Advance Directive DM Patient Action Plan
 Diabetes Safety
 Diet Seat Belt
 ETOH Self Breast Exam
 Exercise Self Testicle Exam
 STD Stress Management
 Wound Care Smoking / Tobacco Cessation
 DM Pocket Card Medication Side Effects
 Reduce Fall Risks Functional Status
 Bladder Control Pain Assessment
 Mental Status Medication Review

Order: (check)

- Basic Metabolic Panel HbA1c
 Complex Metabolic Panel CBC Complete*
 Lipid Panel Urinalysis
 Microalbumin Urine Pneumonia /
*Diagnosis must support need for testing Flu Vaccine

 Other:

TSH. Thyroid

Referrals: DM Mgmt. Class (Health ED)
 DM Retinal Exam

Return Visit:

Days (if not well):

4 Weeks/Months:

marijalil MD Michael Yu Wang, PA



720 AEROVISTA PL SUITE D
SAN LUIS OBISPO, CA 93401
FAX: 800-977-9255
PHONE: 866-239-3784



HOURS OF OPERATION: M-F 8AM - 7PM (Central)

To: MARIAN JALIL, MD
Fax: 562-945-7485

From: Michelle Mehlschau
Date: 05-19-2015

Ext: 216
Pages: 1

Subject: Reina Delahoussaye DOB 12/29/1986

IMPORTANT!

Medical records required to support this patient's prescribed supplies.

Fax to: 800-977-9255

Include progress notes, lab results, hospital records, etc., particularly to justify diagnosis and frequency

We are requesting all Diabetic medical records for all this patient's visits for throughout the past year (2014-2015).

Please know that your patient's insurance requires the diagnosis and blood sugar testing frequency in the records pertaining to their Diabetic Care.

We are grateful for the opportunity to service your patient and working with your office to give them the best service.

If you have any questions, please feel free to call me directly at 844.248.9064 ext 216

Sincerely,
Michelle Mehlschau
Medical Record Team Manager

Thank you
Conversio Health

CONFIDENTIAL

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**PRESCRIPTION REQUEST FOR
HOME DIABETES TESTING SUPPLIES**
Fax Orders to 1-800-977-9255
Questions Call 1-866-239-3784 (DRUG)



Patient Name: REINA DELAHOUSSAYE DOB: 1986-12-29 Home Phone: 5628425856
 Address: 8210 BROADWAY AVE,APT 18 Insurance: ANTHEM BLUE
 City, State, Zip: WHITTIER CA 90606-3525 Member ID: JQ0346M79294

53086864

STEP 1 - DIABETES DIAGNOSIS (250.00-250.93)

ICD9 250.00 ICD9 _____ ICD9 _____ ICD9 _____ VCODE _____

STEP 2 - ITEMS DISPENSED MAY INCLUDE

Blood Glucose Meter Test Strips Control Solution Lancing Device Lancets

Length of need (12 months unless otherwise specified): 12 months OK

STEP 3 - TESTING REGIMEN

Is patient injecting insulin? Yes No

1x/day

2x/day

3x/day

_____ x/day

* Medical records required to support High Frequency testing regimen

Prescriber Name: MARIAN JALIL, MD

Address: 14350 WHITTIER BLVD

City, State, Zip: WHITTIER CA 90605

* Prescriber Signature: _____

Signature Stamps not acceptable

MARIAN JALIL, MD

A40863

Phone: 562-945-7671

Fax: 562-945-7485

NPI: 1801897103

License: _____ Date: 4/1/15

Start date (if different than signature date) _____

Authorized by MARIAN JALIL Printed Name 1 Date: 4/1/15

*If NOT signed by the MD,DO,NP or PA, Medicare requires the prescriber to also sign the rx.

I certify that I am the prescriber identified above and that I have reviewed and approved the order above. I certify that the medical necessity information is true, accurate, and complete. I certify that the patient/caregiver is able to follow instructions for controlling diabetes and is able to use the ordered items. I certify that the patient's medical records and supporting documentation which substantiates the utilization and medical necessity of products listed on order will be provided to Conversio upon request.

Don

53086864





720 AEROVISTA PL SUITE D
SAN LUIS OBISPO, CA 93401
FAX: 800-977-9255
PHONE: 866-239-3784

HOURS OF OPERATION: M-F 8AM - 7PM (Central)



To: MARIAN JALIL, MD
Fax: 562-945-7485

From: Jessica Chavez
Date: 04-01-2015

Ext: 232
Pages: 2

Subject: New Rx Supplies *URGENT: OUT OF SUPPLIES* TESTING 2X/DAY

Dear Doctor:

Your patient's insurance company has partnered with Conversio to provide them medically necessary supplies. Your patient has requested that we contact you for the prescription.

Please complete the attached Rx, sign and date (signature stamps not accepted), and return via fax or mail. We also accept eRx.

Also, to comply with Medicare guidelines, please return medical records, lab results, and/or progress notes related to supporting this patient's coverage, particularly diagnosis and frequency of supplies ordered.

PER INSURANCE GUIDELINES RX MUST BE SIGNED BY MD, PA, OR NP THAT IS PECOS ENROLLED. PLEASE INCLUDE NPI# IF RX IS BEING SIGNED BY SOMEONE OTHER THAN MD.

PLEASE COMPLETE THE FOLLOWING ON THE BLANK RX PROVIDED:

- STEP 1: DIAGNOSIS CODE (ICD9)
- STEP 2: LENGTH OF NEED
- STEP 3: TESTING REGIMEN
- SIGN AND DATE

WE RESPECTFULLY REQUEST CURRENT MEDICAL RECORD DOCUMENTATION FOR YOUR PATIENT INCLUDING LAB RESULTS AND/ OR PROGRESS NOTES THAT INCLUDES DIAGNOSIS AND FREQUENCY OF SUPPLIES ORDERED.

THANK YOU FOR YOUR TIME

Thank you,
Conversio Health

CONFIDENTIAL

The documents accompanying this facsimile transmission contain confidential information belonging to the sender which is legally privileged. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, beware that any disclosure, copying, distribution, or use of the contents of this facsimile information is prohibited. If you have received this facsimile in error, please immediately notify the sender by telephone so arrangements for retrieval can be made at no cost to you. The recipient of this information is prohibited from disclosing the information to any other third party and is required to destroy the information after the stated need has been fulfilled.

EYE CARE CONSULTATION REPORT

TO: Dr. Jalil

RE: Delahoussaye, Reina
DOB 12/29/1986

Exam Date: 3/5/2015

SUBJECTIVE:

Complaints: blurry vision

OBJECTIVE:

ASSESSMENT: * denotes Hierarchical Condition Categories (HCC) Codes

- | | |
|---|--|
| <input checked="" type="checkbox"/> V80.1 No Evidence of Glaucoma | <input type="checkbox"/> 365.71 Mild Stage Glaucoma |
| <input type="checkbox"/> 365.01 Glaucoma Suspect, Low Risk | <input type="checkbox"/> 365.72 Moderate Stage Glaucoma |
| <input type="checkbox"/> 365.05 Glaucoma Suspect, High Risk | <input type="checkbox"/> 365.73 Severe Stage Glaucoma |
| <input type="checkbox"/> 365.04 Ocular Hypertension | <input type="checkbox"/> 365.73 Indeterminate Stage Glaucoma |

- | | | |
|---|---|--|
| <input type="checkbox"/> V72.0 Patient Is Not Diabetic | <input checked="" type="checkbox"/> 250.00 DM II w/o Diabetic Retinopathy | <input type="checkbox"/> 379.23* Vitreous Hemorrhage |
| <input type="checkbox"/> 250.50* & 362.04 Diabetes w/ Ophthalmic Manifestations & Mild Non-Proliferative Diabetic Retinopathy | | |
| <input type="checkbox"/> 250.50* & 362.05 Diabetes w/ Ophthalmic Manifestations & Moderate Non-Proliferative Diabetic Retinopathy | | |
| <input type="checkbox"/> 250.50* & 362.06 Diabetes w/ Ophthalmic Manifestations & Severe Non-Proliferative Diabetic Retinopathy | | |
| <input type="checkbox"/> 250.50* & 362.02* Diabetes w/ Ophthalmic Manifestations & Proliferative Diabetic Retinopathy | | |
| <input type="checkbox"/> 250.50* & 362.07 Diabetes w/ Ophthalmic Manifestations & Diabetic Macular Edema (& code retinopathy stage) | | |

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> 367.0 Hyperopia | <input checked="" type="checkbox"/> 367.1 Myopia | <input type="checkbox"/> 367.21 Astigmatism | <input type="checkbox"/> 367.4 Presbyopia |
| <input type="checkbox"/> 366.16 Senile Cataract | <input type="checkbox"/> 362.50 Macular Degeneration | <input type="checkbox"/> 370.33 Dry Eye | <input type="checkbox"/> 373.00 Blepharitis |

Additional Assessment(s):

PLAN:

- Spectacle Rx/Contact Lens Rx prescribed, return visit for comprehensive eye exam in one year
- Ocular health conditions discussed and treated or managed
- Ophthalmology consultation requested for secondary/tertiary care

Additional Plan(s):

SIGNATURE:


David Ardaya, O.D.

DATE: 03/05/2015



Thank you kindly for your consultation referral. Please contact us with any questions or concerns.



© 1245 E. Washington Blvd., Whittier, CA 90606 Tel: 562-692-1208 Fax: 562-695-6386

○ 1026-B W. West Covina Pkwy., West Covina, CA 91790 Tel: 626-962-5868 Fax: 626-856-0570

Patient Progress Note

Date: Delalious Salje, Reina

Patient Name:

DOS: 3/31/15

DOB:

Age (28)

Sex: M/F

Allergies:

CC: Lab results pls

HPI:

WT: 253 HT: 6'1" BP: 120/90 TEMP: 12.6 P: 84 LMP:
 BMR: 35 Date & Results of Most Recent: HbA1c: 8.7 3/15 LDL: 170 mg/dL See DM Flowsheet
 Microalbumin: / Date of DM Retinal Exam: Eye Exam Report on Chart: Yes No

Systems Examined: (check)

- | | |
|--------------------------|--|
| N | Ab |
| <input type="checkbox"/> | <input type="checkbox"/> Gen. App |
| <input type="checkbox"/> | <input type="checkbox"/> Skin |
| <input type="checkbox"/> | <input type="checkbox"/> Eyes |
| <input type="checkbox"/> | <input type="checkbox"/> Ears |
| <input type="checkbox"/> | <input type="checkbox"/> Nose |
| <input type="checkbox"/> | <input type="checkbox"/> Throat |
| <input type="checkbox"/> | <input type="checkbox"/> Neck |
| <input type="checkbox"/> | <input type="checkbox"/> Heart |
| <input type="checkbox"/> | <input type="checkbox"/> Chest / Lungs |

- | | |
|--------------------------|---|
| N | Ab |
| <input type="checkbox"/> | <input type="checkbox"/> Breast |
| <input type="checkbox"/> | <input type="checkbox"/> Abd. |
| <input type="checkbox"/> | <input type="checkbox"/> Vaginal / Cervix |
| <input type="checkbox"/> | <input type="checkbox"/> Bimanual |
| <input type="checkbox"/> | <input type="checkbox"/> Rectal |
| <input type="checkbox"/> | <input type="checkbox"/> GU / Prostate |
| <input type="checkbox"/> | <input type="checkbox"/> Back |
| <input type="checkbox"/> | <input type="checkbox"/> Extr. |
| <input type="checkbox"/> | <input type="checkbox"/> Neuro |
| <input type="checkbox"/> | <input type="checkbox"/> See Foot Exam Form |

Diagnosis

Status

Plan

DM	OOC	Stat Metformin 1000 BID Endo follow up
Hypoglycemia		
Mental Health		

Patient Education: (check)

- | | |
|--|--|
| <input type="checkbox"/> Advance Directive | <input type="checkbox"/> DM Patient Action Plan |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Safety |
| <input type="checkbox"/> Diet | <input type="checkbox"/> Seat Belt |
| <input type="checkbox"/> ETOH | <input type="checkbox"/> Self Breast Exam |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Self Testicle Exam |
| <input type="checkbox"/> STD | <input type="checkbox"/> Stress Management |
| <input type="checkbox"/> Wound Care | <input type="checkbox"/> Smoking / Tobacco Cessation |
| <input type="checkbox"/> DM Pocket Card | <input type="checkbox"/> Medication Side Effects |
| <input type="checkbox"/> Other: | |

Order: (check)

- | | |
|--|--|
| <input type="checkbox"/> Basic Metabolic Panel | <input type="checkbox"/> HbA1c |
| <input type="checkbox"/> Complex Metabolic Panel | <input type="checkbox"/> CBC Complete* |
| <input type="checkbox"/> Lipid Panel | <input type="checkbox"/> Urinalysis |
| <input type="checkbox"/> Microalbumin Urine | <input type="checkbox"/> Pneumonia / |
- *Diagnosis must support need for testing
- Other:

Flu Vaccine

Referrals:

 DM Mgmt. Class (Health ED) DM Retinal Exam

Return Visit: Days (if not well): Weeks/Months:

Marian Jalil, MD / Marilyn Lee, ANP-C

From:

03/24/15 09:47 P.01/01

APPLECARE MEDICAL GROUP
PO BOX 6014
ARTESIA, CA 907026014
(714) 443-4500

DATE: 3/24/15
TIME: 9:45:43

ATTACHMENTS: _____

RETRO: _____

PATIENT'S INFORMATION---

DELAHOUSAYE, REINA
8210 BROADWAY AVE
APT 18
WHITTIER, CA 90606
PHONE #: ()
BIRTH DATE: 12/29/1986

INSURANCE INFORMATION---

INSURANCE CO.: ANTHEM BLUE CROSS COV
MEMBER #: J00346M79294 20
PLAN CODE: 1G05
EFF. DATE: 03/01/15
VERIFIED BY: WEB
PCP'S NAME: JALIL, MARIAN

PAYMENT OF CLAIM IS SUBJECT TO ELIGIBILITY, CONTRACTUAL LIMITATIONS,
PROVISIONS AND EXCLUSIONS.

REFERRED BY: JALIL, MARIAN
14350 E WHITTIER BLVD
SUITE 200
WHITTIER, CA 906052148

PHONE NUMBER: (562) 945-7671

REFERRED TO: CONVERSIO HEALTH,
720 AEROVISTA PLACE
SUITE D
SAN LUIS OBISPO, CA 934018727

PHONE NUMBER: (866) 239-3784

DIAGNOSIS INFORMATION---
250.00 DMII WO CMP NT ST UNCNTR

PROCEDURE INFORMATION---
A4259 LANCETS PER BOX
A4253 BLOOD GLUCOSE/REAGENT STR

QUANTITY

1

STATUS

APPROVED

2

CO-PAY

APPROVED

AUTHORIZATION NUMBER: 41205671

DATES OF SERVICES: 3/20/15 TO 4/23/15

REASON: RX

AUTHORIZATION COMMENTS:

ADDITIONAL COMMENTS:

(800) 858-8072 Roche
Anyone with Blue Cross diagnostic
free glucose monitor
Christine

Left message 3/24/15 pt has info 3/26/15

Autocheck
Machine
Mail prescription
to pt.
Mailed
today

Referral Request

Request ID: 2015032022260355
Referral Status: REQUESTED
Date Requested: 3/20/2015 11:31:00 AM

[Attachments](#) | Add | View

Referral for REINA DELAHOUSAYE

Patient Name: REINA DELAHOUSAYE	Member ID#: JQ0346M79294-20	DOB: 12/29/1986
Location: Whittier Region	Gender: Female	Age: 28 yr(s)
Health Plan: ANTHEM BLUE CROSS COV CA CO WH	PCP: MARIAN JALIL	Hospital:
Address: 8210 BROADWAY AVE APT 18	City: WHITTIER	Zip: 90606
Phone: (000) 000-0000		
Alert Code :	Risk :	
Aid Code :		

Referring Physician: MARIAN JALIL
Phone: (562) 945-7671 **Fax:** (562) 945-7485
PPG:

Specialty: DURABLE MEDICAL EQUIPMENT PROVIDER	Referred to Provider/Facility: ORTHO ENGINEERING
Address: 14619 WHITTIER BLVD	City: WHITTIER
Phone: (562) 693-6666	Zip: 906051723
	Fax: (562) 693-6667

Priority: ROUTINE **Place Of Service:** Office

CPT®/HCPCS	Modifier	Service Units
E0607 - BLOOD GLUCOSE MONITOR HOM		1
A4259 - LANCETS PER BOX		100
A4253 - BLOOD GLUCOSE/REAGENT STR		50

ICD Codes

250.00 - DMII WO CMP NT ST UNCNTR

Clinical Symptoms/ Findings:

pt needs her diabetic supplies per dr request thank you.

Treatment Plan:

Notification

User	Date and Time	
		No Records

Referral does not guarantee payment for services. All payments are subject to health plan provisions. This referral serves as a recommendation to the claims payor and does not determine the level of benefits paid on the claim nor the eligibility of the patient. The Utilization Management Department is not the claims payor and cannot guarantee payment of any claim. We recommend that you check your benefits before proceeding with any treatment.

Payment of claim is subject to eligibility, contractual limitations and CMS correct coding guidelines.

CPT is a registered trademark of the American Medical Association.

76020042

ACCOUNT # NAME: ADDRESS: CITY, STATE ZIP TELEPHONE:		PATIENT NAME (LAST, FIRST, MIDDLE) <i>LIA JALIL, Reine</i>					
		PATIENT ID / REGISTRATION # <i>76020042</i>	DATE OF BIRTH M M D D YEAR <i>11/13/2017</i>				
		ROOM #	LAB REFERENCE #				
		PATIENT SOCIAL SECURITY #					
		PATIENT PHONE # ()					
		PATIENT STREET ADDRESS					
		APT. # KEY #					
		CITY STATE ZIP					
		PRINT NAME OF INSURED/RESPONSIBLE PARTY (LAST, FIRST, MIDDLE) - IF OTHER THAN PATIENT					
		INSURED ADDRESS					
		CITY STATE ZIP					
		RELATIONSHIP TO INSURED <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT					
		INSURANCE COMPANY NAME / IPA NAME					
		INSURANCE COMPANY ADDRESS CITY ST ZIP					
		INSURANCE ID # GROUP # / DATE OF INJURY					
		MEDICARE # MEDI-CAL #					
		EMPLOYER NAME / EMPLOYER #					
<input type="checkbox"/> ADDIT'L PHYS.: Dr. _____ NPI/UPIN _____ NON-PHYSICIAN PROVIDER: _____ NAME _____ I.D. # _____ <input type="checkbox"/> Fax Results to: () _____ Send Client # OR NAME: _____ Duplicate ADDRESS: _____ Report to: CITY: _____ STATE: _____ ZIP: _____		PRIMARY INSURANCE Medicare @ = May not be covered for the reported diagnosis. Limited F = Has prescribed frequency rules for coverage. Coverage & = A test or service performed with research/experimental kit. Tests B = Has both diagnosis and frequency-related coverage limitations. ICD Codes (enter all that apply) <i>250.00 780.79 872.4</i>					
		Provide signed ABN when necessary					
PANEL COMPONENTS ON BACK ORGAN//DISEASE/PANELS 34392 <input type="checkbox"/> Electrolyte Panel S 10256 <input checked="" type="checkbox"/> Hepatic Function Panel S 10165 <input checked="" type="checkbox"/> Basic Metabolic Panel w/eGFR S 10231 <input checked="" type="checkbox"/> Comp Metabolic Panel w/eGFR S B 76007 <input checked="" type="checkbox"/> Lipid Panel (Fasting Specimen) S B 14852 <input checked="" type="checkbox"/> Lipid Panel w/Reflex LDL S @ 20210 <input type="checkbox"/> Obstetric Panel w/Reflex Y,L,S @ 10306 <input type="checkbox"/> Hepatitis Panel, Acute w/Reflex S 10314 <input type="checkbox"/> Renal Functional Panel w/eGFR S HEMATOLOGY @ 510 <input type="checkbox"/> Hemoglobin L @ 509 <input type="checkbox"/> Hematocrit L @ 1759 <input checked="" type="checkbox"/> CBC (Hgb, Hct, RBC, WBC, Plt) L @ 6399 <input checked="" type="checkbox"/> CBC w/Dif (Hgb, Hct, RBC, WBC, Plt, Diff) L B 8847 <input type="checkbox"/> PT with INR B @ 763 <input type="checkbox"/> PTT, Activated B		OTHER TESTS 823 <input type="checkbox"/> ALT S 243 <input type="checkbox"/> Amylase S 249 <input type="checkbox"/> ANA w/Reflex Titer S 822 <input type="checkbox"/> AST S 4420 <input type="checkbox"/> C-Ractive Protein - CRP S 10124 <input type="checkbox"/> Cardio CRP S B 334 <input type="checkbox"/> Cholesterol, Total S 374 <input type="checkbox"/> CK, Total S 375 <input type="checkbox"/> Creatinine (CR) w/eGFR S @ 457 <input type="checkbox"/> Ferritin S 470 <input type="checkbox"/> FSH S B 482 <input type="checkbox"/> GGT S 8477 <input type="checkbox"/> Glucose Gest. Screen GY B 483 <input type="checkbox"/> Glucose, Serum S B 3396 <input type="checkbox"/> HCG, Serum, Quant S B 496 <input type="checkbox"/> Hemoglobin A1C L 498 <input type="checkbox"/> Hep B Surface Ag w/Reflex Confirm S B 8472 <input type="checkbox"/> Hep C Virus Ab S B 19728 <input type="checkbox"/> HIV-1/HIV-2 Scr w/Reflexes S @ 7573 <input type="checkbox"/> Iron (Total), IBC, % Sat S		@ 571 <input type="checkbox"/> Iron, Total S 593 <input type="checkbox"/> LDH S 599 <input type="checkbox"/> Lead (B) TN 622 <input type="checkbox"/> Magnesium S 6517 <input type="checkbox"/> Microalbumin, Random Urine w/Creat Fecal Globin, Feces - FIT, InSure® @ 11290 <input type="checkbox"/> DX F 11293 <input type="checkbox"/> Mcr Scr S 718 <input type="checkbox"/> Phosphorus S B 5363 <input type="checkbox"/> PSA, Total S 4418 <input type="checkbox"/> Rheumatoid Factor S 799 <input type="checkbox"/> RPR (Monitoring) w/ReflexTiter S 36126 <input type="checkbox"/> RPR (DX) w/Reflex Confirm S 809 <input type="checkbox"/> SED Rate by Mod West S B 899 <input type="checkbox"/> TSH S B 36127 <input type="checkbox"/> TSH w/Reflex T-4, Free S 34429 <input type="checkbox"/> T-3, Free S 859 <input type="checkbox"/> T-3, Total S B 861 <input type="checkbox"/> T-3 Uptake S B 867 <input type="checkbox"/> T-4 (Thyroxine), Total S B 866 <input type="checkbox"/> T-4 (Thyroxine), Free S		15983 <input type="checkbox"/> Testosterone, Total, LC/MS/MS SR 873 <input type="checkbox"/> Testosterone, Total, Male SR 6448 <input type="checkbox"/> UA, Dipstick Only U 7909 <input type="checkbox"/> UA, Dipstick, w/Reflex Microscopic U 5463 <input type="checkbox"/> UA, Complete (Dipstick & Microscopic) U @ 3020 <input type="checkbox"/> UA, Complete, w/Reflex Culture S 294 <input type="checkbox"/> Urea Nitrogen (BUN) S 905 <input type="checkbox"/> Uric Acid S 927 <input type="checkbox"/> Vitamin B12 S 7065 <input type="checkbox"/> Vitamin B12/Folic Acid S 17306 <input type="checkbox"/> Vitamin D QuesAsure/25-OH D, LC/MS/MS SR MICROBIOLOGY Source (Required) _____ 4550 <input type="checkbox"/> Culture, Aerobic Bacteria* 5617 <input type="checkbox"/> Culture, Group B Strep* 394 <input type="checkbox"/> Culture, Throat* @ 395 <input type="checkbox"/> Culture, Urine Routine*	
		Amplified Specimen Type (Optimal) <input type="checkbox"/> Endocervical <input type="checkbox"/> Urethral <input type="checkbox"/> Urine 11363 <input type="checkbox"/> Chlamydia & N. gonorrhoeae RNA, TMA					
() 8435 HCG, TOTAL, RL <i>Men urine</i> <i>HbA1C 8181</i> <i>TA Crif ind</i> <i>TSH / Thyroid 2444</i>							
ADDITIONAL TESTS: (MUST INCLUDE COMPLETE TEST NAME AND ORDER CODE. REFER TO DIRECTORY OF SERVICES.)				* Additional charge for ID/Susceptibility studies. Reflex tests are performed at an additional charge.			
COMMENTS, CLINICAL INFORMATION:		TOTAL TESTS ORDERED		+ 76020042 7226272 + 76020042 7226272			
Physician Signature		For any patient of any payor (including Medicare and Medicaid), only order those tests which are medically necessary for the diagnosis and treatment of the patient.		NAME: 76020042 7226272 11/13/2017 76020042 7226272			

All samples to be shipped in 2 specimen
3020 UA, Complete Reflex to Culture REQUIRES 2 specimens

Specimen Key:

B	=	Blue top tube
BX	=	Unopened Barrier tube
FBP	=	Frozen Plasma Blue top tube
FP	=	Frozen Plasma
FS	=	Frozen Serum
GN	=	Green top tube (Sodium Heparin)
GY	=	Gray top tube

S	=	Yellow top tube
TN	=	Yellow top tube
U	=	Yellow top tube
Y	=	Yellow top tube

x Fill Line, Preservative tube

All reflex tests will be performed at an additional charge.

Test Code	Profile Components	34392 Electrolyte Panel	10256 Hepatic Function Panel	10165 Basic Metabolic Panel w/eGFR	10231 Comp Metabolic Panel w/eGFR	7600 Lipid Panel	Lipid Reflex v/L	20210 Obstetric Panel w/Reflex	10306 Hepatitis Panel Acute w/Reflex	10314 Renal Functional Panel w/eGFR
836	Sodium	X		X	X					X
733	Potassium	X		X	X					X
330	Chloride	X		X	X					X
310	Carbon Dioxide	X		X	X					X
223	Albumin		X		X					
285	Bilirubin, Direct		X							
287	Bilirubin, Total		X		X					
234	Alk. Ame Phosphatase		X		X					
822	AST		X		X					
823	ALT		X		X					
754	Protein, Total		X		X					
303	Calcium			X	X					X
483	Glucose, Serum			X	X					X
294	Urea Nitrogen			X	X					X
375	Creatinine			X	X					X
334	Cholesterol, Total					X	X			
896	Triglycerides					X	X			
608	HDL					X	X			
718	Phosphorus									X
8293	d-LDL v/HDL Trig >400						X			
7788	ABO/Rh							X		
795	Antibody Scr RBC w/reflex							X		
1759	CBC							X		
36126	RPR w/ret.ex confirm							X		
498	HBsAg w/reflex confirm							X	X	
802	Rubella IgG Ab							X		
8472	HC Ab								X	
512	HA Ab IgM								X	
4848	HBcAb IgM								X	

Patients: Minimize your wait time by scheduling an appointment at a convenient Patient Service Center.

To find a location and make an appointment visit us at QuestDiagnostics.com/appointment or call 888-277-8772 or simply download our mobile app. at QuestDiagnostics.com/mobile





Quest
Diagnostics



760200-7 722627-

MARIAM JALIL, M.D.

ACCOUNT #:

NAME: 14350 WHITTIER BLVD STE 200
ADDRESS: CITY, STATE: WHITTIER, CA 90605-2148

TELEPHONE #: 562-945-7671

DATE COLLECTED	TIME	<input type="checkbox"/> AM	TOTAL VOL/HRS.	<input type="checkbox"/> Fasting
		<input type="checkbox"/> PM	ML HR	<input type="checkbox"/> Non Fasting

NPI/UPIN ORDERING/SUPERVISING PHYSICIAN AND/OR PAYORS (MUST BE INDICATED)

() 1801897103 JALIL, MARIAM

DID YOU KNOW

Service Center location
and appointment scheduling
information is on the back.

Each sample should be labeled
with at least two patient identifiers
at time of collection.

BILL TO:		PATIENT NAME (LAST, FIRST, MIDDLE)		
<input type="checkbox"/> MY ACCOUNT <input type="checkbox"/> PATIENT <input type="checkbox"/> MEDICARE <input type="checkbox"/> RAILROAD MEDICARE <input type="checkbox"/> Medi-Cal <input type="checkbox"/> L.Jard/Select <input type="checkbox"/> OTHER INSURANCE		1801897103, Reina		
PATIENT ID / REGISTRATION #		DATE <u>MM DD YEAR</u>		SEX
ROOM #		LAB REFERENCE #		

PATIENT SOCIAL SECURITY # PATIENT PHONE # ()

PATIENT STREET ADDRESS APT. # KEY #

CITY STATE ZIP

PRINT NAME OF INSURED/RESPONSIBLE PARTY (LAST, FIRST, MIDDLE) - IF OTHER THAN PATIENT

INSURED ADDRESS

CITY STATE ZIP

RELATIONSHIP TO INSURED SELF SPOUSE DEPENDENT

INSURANCE COMPANY NAME / IPA NAME

INSURANCE COMPANY ADDRESS CITY ST ZIP

INSURANCE ID # GROUP # / DATE OF INJURY

MEDICARE # MEDI-CAL #

EMPLOYER NAME / EMPLOYER #

Medicare @ = May not be covered for the reported diagnosis.
Limited F = Has prescribed frequency rules for coverage.
Coverage & = A test or service performed with research/experimental kit.
Tests B = Has both diagnosis and frequency-related coverage limitations.

Provide
signed
ABN when
necessary

ICD Codes (enter all that apply)

250.00 780.79 872.4

<input type="checkbox"/> ADDIT'L PHYS.: Dr.	NPI/UPIN
NON-PHYSICIAN PROVIDER:	NAME I.D.#
<input type="checkbox"/> Fax Results to: ()	
Send Duplicate Report to:	Client # OR NAME: ADDRESS: CITY: STATE ZIP

STATE ZIP

PANEL COMPONENTS ON BACK

ORGAN//DISEASE(PANELS)

- 34392 Electrolyte Panel S
- 10256 Hepatic Function Panel S
- 10165 Basic Metabolic Panel w/eGFR S
- 10231 Comp Metabolic Panel w/eGFR S
- B 7600 Lipid Panel (Fasting Specimen) S
- B 14852 Lipid Panel w/Reflex DLDL S
- @ 20210 Obstetric Panel w/Reflex YLS
- @ 10306 Hepatitis Panel, Acute w/Reflex S
- 10314 Renal Functional Panel w/eGFR S

HEMATOLOGY

- @ 510 Hemoglobin L
- @ 509 Hematocrit L
- @ 1755 CBC (Hgb, Hct, RBC, WBC, Plt) L
- @ 6399 CBC w/Diff (Hgb, Hct, RBC, WBC, Plt, Diff) L
- B 8847 PT with INR B
- @ 763 PTT, Activated B

() 8435 HCG, TOTAL, RL

Men urine

HbA1C 8181

VA CT if ind

TSH / Thyroid 2444

ADDITIONAL TESTS: (MUST INCLUDE COMPLETE TEST NAME AND ORDER CODE. REFER TO DIRECTORY OF SERVICES.)

* Additional charge for ID/Susceptibility studies.
Reflex tests are performed at an additional charge.

+ REQUEST

PRINTER
All samples to be sent to lab at ambient, unless otherwise specified.
3020 UA, Complete Reflex to Culture RÉQUIER 2 specimens: Yellow Cap Urine Vial with Blue Filler and a Gray top urine transport tube

Specimen Key:	B = Blue top tube	HB = Human breath
	BX = Unopened Barrier tube	LB = Lavender top tube
	FBP = Frozen Plasma Blue top tube	SR = Serum from a Red top tube
	FP = Frozen Plasma	S = Serum or Spun Barrier tube (SST)
	FS = Frozen Serum	TN = Tan top tube (EDTA)
	GN = Green top tube (Sodium Heparin)	U = Yellow top (Screw Cap Vial), Blue Fill Line, Preservative tube
	GY = Gray top tube	Y = Yellow top

All reflex tests will be performed at an additional charge:

Test Code	Profile Components	34392 Electrolyte Panel	10256 Hepatic Function Panel	10165 Basic Metabolic Panel w/eGFR	10231 Comp Metabolic Panel w/eGFR	7600 Lipid Panel	14852 Lipid Panel w/Reflex d-LDL	20210 Obstetric Panel w/Reflex	10306 Hepatitis Panel Acute w/Reflex	10314 Renal Functional Panel w/eGFR
636	Sodium	X		X	X					X
733	Potassium	X		X	X					X
330	Chloride	X		X	X					X
310	Carbon Dioxide	X		X	X					X
223	Albumin		X		X					X
285	Bilirubin, Direct		X							
287	Bilirubin, Total		X		X					
234	Alkaline Phosphatase		X		X					
822	AST		X		X					
823	ALT		X		X					
754	Protein, Total		X		X					
303	Calcium			X	X					X
483	Glucose, Serum			X	X					X
294	Urea Nitrogen			X	X					X
375	Creatinine			X	X					X
334	Cholesterol, Total					X	X			
896	Triglycerides					X	X			
608	HDL					X	X			
718	Phosphorus									X
8293	d-LDL when Trig >100						X			
7788	ABO/Rh							X		
793	Antibody Scr RBC v. reflex							X		
1759	GBC							X		
36126	RPR w/reflex confirm							X		
498	HBsAg w/reflex confirm							X	X	
802	Rubeola IgG Ab							X		
8472	HC Ab								X	
512	HA Ab IgM								X	
4848	HBcAb IgM								X	

Marian Jalil, MD, Inc
Patient Progress Note

Reine 3-10 15' Patient Name J. E. B. Haussagel DOS: DOB: 12/29/86 Age: 28 Sex (M/F) M
Allergies: NKA Non Smoker
CC: Here for eye check up - Physical examination
HPI: No colds in

WT: 255 HT: 6' BP: 118/70 TEMP: P: 78 R: LMP: 3/6/15
BMI: 34 Date & Results of Most Recent HbA1c: 01/04/11.9 LDL: - / - See DM Flowsheet
Microalbumin / Date of DM Retinal Exam / Eye Exam report on Chart: Yes No

(Check) ✓ systems examined

N	Ab	N	Ab	N	Ab
<input type="checkbox"/>	<input type="checkbox"/> Gen. App	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/> GU / Prostate
<input type="checkbox"/>	<input type="checkbox"/> Skin	<input type="checkbox"/>	<input type="checkbox"/> Heart	<input type="checkbox"/>	<input type="checkbox"/> Back
<input type="checkbox"/>	<input type="checkbox"/> Eyes	<input type="checkbox"/>	<input type="checkbox"/> Chest / Lung	<input type="checkbox"/>	<input type="checkbox"/> Extr.
<input type="checkbox"/>	<input type="checkbox"/> Ears	<input type="checkbox"/>	<input type="checkbox"/> Breast	<input type="checkbox"/>	<input type="checkbox"/> Nuero
<input type="checkbox"/>	<input type="checkbox"/> Nose	<input type="checkbox"/>	<input type="checkbox"/> Abdomen	<input type="checkbox"/>	<input type="checkbox"/> See Foot Exam Form
<input type="checkbox"/>	<input type="checkbox"/> Throat	<input type="checkbox"/>	<input type="checkbox"/> Rectal		

Diagnosis

Status

Plan

Patient Education: (Check) ✓

- Advance Directive
 - Diabetes
 - Diet
 - ETOH
 - Exercise
 - STD
 - Wound Care
 - DM Pocket Card
 - Other:
 - DM Patient Action Plan
 - Safety
 - Seat Belt
 - Self Breast Exam
 - Self Testicle Exam
 - Stress Management
 - Smoking/Tobacco Cessation
 - Medication Side Effects

Order-

- Basic Metabolic Panel
 - Complex Metabolic Panel
 - Lipid Panel *(X)*
 - Microalbumin urine
 - HbA1C
 - CBC Complete*
 - Urinalysis
 - Pneumonia/Flu Vaccine

Other-

- Referrals: DM Mgmt. Class (Health ED)
 DM Retinal Exam

Return Visit:

Days (if not well)

26 Weeks Months

Marian Jalil, MD, Inc
Patient Progress Note

Patient Name Debhoussaye, Reina DOS: 2/11/15 DOB: 12/29/86 Age: 28 Sex (M/F) F

Allergies:

CC: Here for ✓ up Bc covering from GILL
Dyspnea Valit 50B c EXERTION

HPI: Cough since Friday - sub. fever

WT: 252 HT: 5'1' BP: 139/83 TEMP: 88 P: 119 R: 14 LMP:

BMI: 35 Date & Results of Most Recent: HbA1c 11.9 / LDL: 1 See DM Flowsheet

Microalbumin Date of DM Retinal Exam 11/9/14 Eye Exam report on Chart: Yes No

02/8/15

(Check) ✓ systems examined

N	Ab	N	Ab	N	Ab
<input type="checkbox"/>	<input type="checkbox"/> Gen. App	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/> GU / Prostate
<input type="checkbox"/>	<input type="checkbox"/> Skin	<input type="checkbox"/>	<input type="checkbox"/> Heart	<input type="checkbox"/>	<input type="checkbox"/> Back
<input type="checkbox"/>	<input type="checkbox"/> Eyes	<input type="checkbox"/>	<input checked="" type="checkbox"/> Chest / Lung <i>QHONKU</i>	<input type="checkbox"/>	<input type="checkbox"/> Extr.
<input checked="" type="checkbox"/>	<input type="checkbox"/> Ears	<input type="checkbox"/>	<input type="checkbox"/> Breast <i>Bulbous</i>	<input type="checkbox"/>	<input type="checkbox"/> Nuero
<input checked="" type="checkbox"/>	<input type="checkbox"/> Nose	<input type="checkbox"/>	<input type="checkbox"/> Abdomen	<input type="checkbox"/>	<input type="checkbox"/> See Foot Exam Form
<input type="checkbox"/>	<input checked="" type="checkbox"/> Throat	<input type="checkbox"/>	<input type="checkbox"/> Rectal		

Diagnosis

Acute Bronchitis

Status

Plan

Albuterol 475 mg
pen

OTC Cough

T fluid + rest

Patient Education: (Check) ✓

- Advance Directive DM Patient Action Plan
- Diabetes Safety
- Diet Seat Belt
- ETOH Self Breast Exam
- Exercise Self Testicle Exam
- STD Stress Management
- Wound Care Smoking/Tobacco Cessation
- DM Pocket Card Medication Side Effects
- Other: *to follow*

Order:

- Basic Metabolic Panel HbA1C
- Complex Metabolic Panel CBC Complete*
- Lipid Panel Urinalysis
- Microalbumin urine Pneumonia/Flu Vaccine

*Diagnosis must support need for testing

Other:

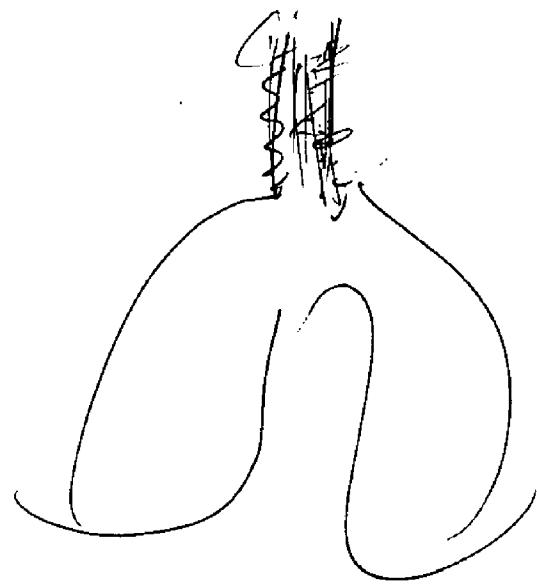
- DM Mgmt. Class (Health ED)
- DM Retinal Exam

Return Visit:

Days (if not well)

Weeks/Months

Marian Jalil, MD, Inc.



Marian Jalil, MD, Inc

Patient Progress Note

Patient Name: Doyle, James DOS: _____ DOB: _____ Age: _____ Sex (M/F) _____

Allergies:

CC: [REDACTED] [REDACTED] [REDACTED]

HPI: _____

WT: _____ HT: _____ BP: _____ TEMP: _____ P: _____ R: _____ LMP: _____

BMI: Date & Results of Most Recent HbA1c / LDL: / See DM Flowsheet

Microalbumin / Date of DM Retinal Exam: _____ / Eye Exam report on Chart: Yes No

(Check) ✓ systems examined

New Appointment		N	Ab	N	Ab	N	Ab	
<input type="checkbox"/>	<input type="checkbox"/>	Gen. App	<input type="checkbox"/>	<input type="checkbox"/>	Neck	<input type="checkbox"/>	<input type="checkbox"/>	GU / Prostate
<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	Head	<input type="checkbox"/>	<input type="checkbox"/>	Back
<input type="checkbox"/>	<input type="checkbox"/>	Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Chest / Lung	<input type="checkbox"/>	<input type="checkbox"/>	Ext.
<input type="checkbox"/>	<input type="checkbox"/>	Ears	<input type="checkbox"/>	<input type="checkbox"/>	Breast	<input type="checkbox"/>	<input type="checkbox"/>	Nuero
<input type="checkbox"/>	<input type="checkbox"/>	Nose	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	See Foot Exam Form
<input type="checkbox"/>	<input type="checkbox"/>	Throat	<input type="checkbox"/>	<input type="checkbox"/>	Rectal	<input type="checkbox"/>	<input type="checkbox"/>	
Instructions given: _____								

Diagnosis

status

Plan

	Doctor's Signature: _____	
	Clerk or Nurse Initial: _____	

Patient Education: (Check) ✓

- Advance Directive
 - Diabetes
 - Diet
 - ETOH
 - Exercise
 - STD
 - Wound Care
 - DM Pocket Card
 - Other:
 - DM Patient Action Plan
 - Safety
 - Seat Belt
 - Self Breast Exam
 - Self Testicle Exam
 - Stress Management
 - Smoking/Tobacco Cessation
 - Medication Side Effects

Order:

- Basic Metabolic Panel
 - Complex Metabolic Panel
 - Lipid Panel
 - Microalbumin urine
 - HbA1C
 - CBC Complete*
 - Urinalysis
 - Pneumonia/Flu Vaccine

***Diagnosis must supercede for testing.**

Other-

- Referrals: DM Mgmt. Class (Health ED)
 DM Retinal Exam

Return Visit: _____ **Days (if not well)** _____ **Weeks/Months** _____



76020042-7 2899089-

MARIAH JALIL, M.D.
 ACCOUNT #: 14350 WHITTIER BLVD STE 200
 NAME: WHITTIER, CA 90605-2148
 ADDRESS:
 CITY, STATE, ZIP

TELEPHONE #: 562-945-7671

DID YOU KNOW?

**Patient Service Center location
and appointment scheduling
information is on the back.**

**Each sample should be labeled
with at least two patient identifiers
at time of collection.**

BILL TO:
 MY ACCOUNT
 PATIENT
 MEDICARE
 RAILROAD MEDICARE
 Medi-Cal
 Lab Card/Select
 OTHER INSURANCE

PRINT PATIENT NAME (LAST, FIRST, MIDDLE)

Debra housay

Reina

PATIENT ID / REGISTRATION #

 DATE M M D D YEAR
 OF BIRTH

ROOM #

LAB REFERENCE #

PATIENT SOCIAL SECURITY #

()

PATIENT PHONE #

APT. # KEY #

PATIENT STREET ADDRESS

CITY

STATE

ZIP

PRINT NAME OF INSURED/RESPONSIBLE PARTY (LAST, FIRST, MIDDLE) - IF OTHER THAN PATIENT

INSURED ADDRESS

CITY

STATE

ZIP

RELATIONSHIP TO INSURED SELF SPOUSE DEPENDENT

INSURANCE COMPANY NAME / IPA NAME

INSURANCE COMPANY ADDRESS

CITY

ST ZIP

INSURANCE ID #

GROUP # / DATE OF INJURY

MEDICARE #

MEDI-CAL #

EMPLOYER NAME / EMPLOYER #

Medicare @= May not be covered for the reported diagnosis.
Limited F = Has prescribed frequency rules for coverage.
Coverage & = A test or service performed with research/experimental kit.
Tests B = Has both diagnosis and frequency-related coverage limitations.

 Provide signed
ABN when
necessary
ICD Codes (enter all that apply)

250.00 180.79 212.4

PANEL COMPONENTS ON BACK ORGAN/DISEASE/PANELS 34392 <input type="checkbox"/> Electrolyte Panel S 10256 <input checked="" type="checkbox"/> Hepatic Function Panel S 10165 <input type="checkbox"/> Basic Metabolic Panel w/eGFR S 10221 <input checked="" type="checkbox"/> Comp Metabolic Panel w/eGFR S B 7600 <input type="checkbox"/> Lipid Panel (Fasting Specimen) S B 14852 <input type="checkbox"/> Lipid Panel w/Reflex DLDL S @ 20210 <input type="checkbox"/> Obstetric Panel w/Reflex Y,L,S @ 10306 <input type="checkbox"/> Hepatitis Panel, Acute w/Reflex S 10314 <input type="checkbox"/> Renal Functional Panel w/eGFR S HEMATOLOGY @ 510 <input type="checkbox"/> Hemoglobin L @ 509 <input type="checkbox"/> Hematocrit L @ 1759 <input type="checkbox"/> CBC (Hgb, Hct, RBC, WBC, Plt) L @ 63995 <input type="checkbox"/> CBC w/Diff (Hgb, Hct, RBC, WBC, Plt, Diff) L B 8847 <input type="checkbox"/> PT with INR B @ 763 <input type="checkbox"/> PTT, Activated B	OTHER TESTS 823 <input type="checkbox"/> ALT S 243 <input type="checkbox"/> Amylase S 249 <input type="checkbox"/> ANA w/Reflex Titer S 822 <input type="checkbox"/> AST S 4420 <input type="checkbox"/> C-Ractive Protein - CRP S 10124 <input type="checkbox"/> Cardio CRP S B 334 <input type="checkbox"/> Cholesterol, Total S 374 <input type="checkbox"/> CK, Total S 375 <input type="checkbox"/> Creatinine (CR) w/eGFR S @ 457 <input type="checkbox"/> Ferritin S 470 <input type="checkbox"/> FSH S B 482 <input type="checkbox"/> GGT S 8477 <input type="checkbox"/> Glucose Gest. Screen GY B 483 <input type="checkbox"/> Glucose, Serum S B 8396 <input type="checkbox"/> HCG, Serum, Quant S B 496 <input type="checkbox"/> Hemoglobin A1C L 498 <input type="checkbox"/> Hep B Surface Ag w/Reflex Confirm S 8072 <input type="checkbox"/> Hep C Virus Ab S B 19728 <input type="checkbox"/> HIV-1/HIV-2 Scr w/Reflexes S @ 753 <input type="checkbox"/> Iron (Total), IBC, % Sat S	@ 571 <input type="checkbox"/> Iron, Total S 593 <input type="checkbox"/> LDH S 599 <input type="checkbox"/> Lead (B) TN 622 <input type="checkbox"/> Magnesium S 6517 <input type="checkbox"/> Microalbumin, Random Urine w/Creat Fecal Globin, Feces - FIT, InSure™ @ 11290 <input type="checkbox"/> DX F 11293 <input type="checkbox"/> Mcr Scr 718 <input type="checkbox"/> Phosphorus S B 5363 <input type="checkbox"/> PSA, Total S 4418 <input type="checkbox"/> Rheumatoid Factor S 799 <input type="checkbox"/> RPR (Monitoring) w/Reflex Titer S 36126 <input type="checkbox"/> RPR (DX) w/Reflex Confirm S 809 <input type="checkbox"/> SED Rate by Mod West S B 899 <input type="checkbox"/> TSH S B 36127 <input type="checkbox"/> TSH w/Reflex T-4, Free S 34429 <input type="checkbox"/> T-3, Free S 859 <input type="checkbox"/> T-3, Total S B 861 <input type="checkbox"/> T-3 Uptake S B 867 <input type="checkbox"/> T-4 (Thyroxine), Total S B 866 <input type="checkbox"/> T-4 (Thyroxine), Free S	15983 <input type="checkbox"/> Testosterone, Total, LC/MS/MS SR 873 <input type="checkbox"/> Testosterone, Total, Male SR 6448 <input type="checkbox"/> UA, Dipstick Only U 7809 <input type="checkbox"/> UA, Dipstick, w/Reflex Microscopic U 5463 <input type="checkbox"/> UA, Complete (Dipstick & Microscopic) U @ 3020 <input type="checkbox"/> UA, Complete, w/Reflex Culture 294 <input type="checkbox"/> Urea Nitrogen (BUN) S 905 <input type="checkbox"/> Uric Acid S 927 <input type="checkbox"/> Vitamin B12 S 7065 <input type="checkbox"/> Vitamin B12/Folic Acid S 17305 <input checked="" type="checkbox"/> Vitamin D, 25 Hydroxy, LC/MS/MS SR
MICROBIOLOGY			
Source (Required)			
S 4550 <input type="checkbox"/> Culture, Aerobic Bacteria*			
S 5617 <input type="checkbox"/> Culture, Group B Strep*			
S 394 <input type="checkbox"/> Culture, Throat*			
S @ 395 <input type="checkbox"/> Culture, Urine Routine*			
Amplified Specimen Type (please check one)			
S <input type="checkbox"/> Endocervical <input type="checkbox"/> Urethral <input type="checkbox"/> Urine			
S 17305 <input type="checkbox"/> Chlamydia & N. gonorrhoeae DNA, SDA			

tsh thyroid panel 7444
 HbA1c 8181
 UA cts if and

() 17303 CHLAMYDIA DNA, SDA
 () 17305 CT/NG DNA, SDA
 () 8435 HCG, TOTAL, QL
 () 17304 NG DNA, SDA

ADDITIONAL TESTS: (MUST INCLUDE COMPLETE TEST NAME AND ORDER CODE. REFER TO DIRECTORY OF SERVICES.)

* Additional charge for ID/Susceptibility studies.

Reflex tests are performed at an additional charge.

COMMENTS, CLINICAL INFORMATION:

 TOTAL TESTS
ORDERED

REFERRING

+ +

76020042

2899089

76020042

2899089

NAME: _____

76020042

2899089

76020042

2899089

Physician Signature
 For any patient of any payor (including Medicare and Medicaid), only
 order those tests which are medically necessary for the diagnosis and
 treatment of the patient

All samples to be shipped ambient, unless otherwise specified.
3020 UA, Complete Reflex to Culture REQUIRES 2 specimens, Yellow Cap Urine Vial with B' Line and a Gray top urine transport tube

Specimen Key:	B = Blue top	HB = Human birth
	BX = Unopened Barrier tube	L = Lavender top tube
	FBP = Frozen Plasma Blue top tube	SR = Serum from a Red top tube
	FP = Frozen Plasma	S = Serum or Spun Barrier tube (SST)
	FS = Frozen Serum	TN = Tan top tube (EDTA)
	GN = Green top tube (Sodium Heparin)	U = Yellow top (Screw Cap Vial), Blue Fill Line, Preservative tube
	GY = Gray top tube	Y = Yellow top tube

All reflex tests will be performed at an additional charge.

Test Code	Profile Components	34392 Electrolyte Panel	10256 Hepatic Function Panel	10165 Basic Metabolic Panel w/eGFR	10231 Comp Metabolic Panel w/eGFR	7600 Lipid Panel	14852 Lipid Panel w/Reflex d-LDL	20210 Obstetric Panel w/Reflex	10306 Hepatitis Panel Acute w/Reflex	10314 Renal Functional Panel w/eGFR
836	Sodium	X		X	X					X
733	Potassium	X		X	X					X
330	Chloride	X		X	X					X
310	Carbon Dioxide	X		X	X					X
223	Albumin		X		X					X
285	Bilirubin, Total		X		X					
287	Bilirubin, Direct		X							
234	Alkaline Phosphatase		X		X					
822	AST		X		X					
823	ALT		X		X					
754	Protein, Total		X		X					
303	Calcium			X	X					X
483	Glucose, Serum			X	X					X
294	Urea Nitrogen			X	X					X
375	Creatinine			X	X					X
334	Cholesterol, Total					X	X			
896	Triglycerides					X	X			
608	HDL					X	X			
718	Phosphorus									X
8293	d-LDL when Trig >400						X			
7788	ABO/Rh							X		
795	Antibody Sci RBC w/reflex							X		
1759	CBC							X		
36126	RPR w/reflex confirm							X		
498	HBsAg w/reflex confirm							X	X	
802	Rubella IgG Ab							X		
8472	HC Ab								X	
512	HA Ab IgM								X	
4848	HBcAb IgM								X	

CHILDHOOD ALLERGY PROFILE (Food/Environmental) TEST CODE: 10659 (X)

D. pteronyssinus, d1; D. farinae, d2; Cat dander, e1; Dog dander, e5; Egg white, f1; Milk, f2; Codfish, f3; Wheat, f4; Peanuts, f13; Soybean, f14; Shrimp, f24; Walnut, f256; Cockroach, i6; Cladosporium herbarum, m2; Alternaria alternate, m6; Total IgE.

FOOD ALLERGY PROFILE TEST CODE: 10715 (X)

Egg white, f1; Milk, f2; Codfish, f3; Wheat, f4; Corn, f8; Sesame Seed, f10; Peanuts, f13; Soybean, f14; Shrimp, f24; Clam, f207; Walnut, f256; Scallop, f338; Total IgE.

REGION: # 12 AZ, S. (DESERT); CA, S. (DESERT) TEST CODE: 10654 (X)

Outdoor mold (Alternaria alternata), m6; Indoor mold (Aspergillus fumigatus), m3; Acacia species, t19; Bermuda grass, g2; Cat dander, e1; Mold (Cladosporium herbarum), m2; Cockroach, i6; Common (rough) pigweed, w14; Common ragweed, w1; Cottonwood, t14; Dog dander, e5; Elm, t8; House dust mite, d1; House dust mite, d2; Johnson grass, g10; Mountain juniper, t6; Mugwort, w6; Oak, t7; Olive, t9; Penicillium notatum, m1; Rye-grass, g5; Saltwort, Russian thistle, w11; Total IgE.

REGION: # 13 CA, S. (COASTAL) TEST CODE: 10655 (X)

Outdoor mold (Alternaria alternata), m6; Indoor mold (Aspergillus fumigatus), m3; Bermuda grass, g2; Cat dander, e1; Mold (Cladosporium herbarum), m2; Cockroach, i6; Common (rough) pigweed, w14; Common ragweed, w1; Cottonwood, t14; Dog dander, e5; Elm, t8; Grey alder, t2; House dust mite, d1; House dust mite, d2; Johnson grass, g10; Mountain juniper, t6; Mugwort, w6; Mulberry, t70; Oak, t7; Olive, t9; Penicillium notatum, m1; Saltwort, Russian thistle, w11; Timothy grass, g6; Walnut, t10; Total IgE.

REGION: # 14 CA, CENTRAL TEST CODE: 10668 (X)

Outdoor mold (Alternaria alternata), m6; Indoor mold (Aspergillus fumigatus), m3; Box-elder (Maple), t1; Cat dander, e1; Mold (Cladosporium herbarum), m2; Cockroach, i6; Common (rough) pigweed, w14; Common ragweed, w1; Common silver birch, t3; Cottonwood, t14; Dog dander, e5; Elm, t8; Grey alder, t2; House dust mite, d1; House dust mite, d2; Maple leaf sycamore, t1; Mountain juniper, t6; Mugwort, w6; Mulberry, t70; Oak, t7; Olive, t9; Penicillium notatum, m1; Saltwort, Russian thistle, w11; Timothy grass, g6; Walnut, t10; White ash, t15; Total IgE.

REGION: # 17 CA, NW; OR, W; WA TEST CODE: 10658 (X)

Outdoor mold (Alternaria alternata), m6; Indoor mold (Aspergillus fumigatus), m3; Box-elder (Maple), t1; Cat dander, e1; Mold (Cladosporium herbarum), m2; Cockroach, i6; Common (rough) pigweed, w14; Common ragweed, w1; Common silver birch, t3; Cottonwood, t14; Dog dander, e5; Elm, t8; Grey alder, t2; House dust mite, d1; House dust mite, d2; Mountain juniper, t6; Nettle, w20; Oak, t7; Penicillium notatum, m1; Sheep sorrel, w18; Timothy grass, g6; Walnut, t10; White ash, t15; Total IgE.

Patients: Minimize your wait time by scheduling an appointment at a convenient Patient Service Center.

To find a location and make an appointment visit us at QuestDiagnostics.com/appointment or call 888-277-8772 or simply download our mobile app. at QuestDiagnostics.com/mobile



FEMALE PHYSICAL

Name: DeJalbousine Reina Date: 1/22/14 Chart#:
 Age: 27 Immunizations Current: [] Yes [] No Doctor:
 Medical History:

Gyn History: LMP: 1/4/14 *(Physical March 2013)*
 Family History: Smoking Alcohol *(Last Oct 2013)*

Social History:

Wt: 254 Ht: 5'11" BP: 100/78 P: R: T:
 Vision: Right: Left: Both:
 Normal () If Abnormal, Describe Below:

Skin:	—	
Eyes:	—	
ENT:	—	
Thyroid:	—	
Lungs:	—	
Heart:	—	
Breasts:	—	
Abdomen:	—	
Ext Genitalia:	—	
Vagina:	—	
Discharge:	—	Creamy white nonodorous discharge
Cervix:	—	
Uterus:	—	Pap done: [X] Yes [] No <i>(Cervix)</i>
Adnexae:	—	
Rectal:	—	
Neuro:	—	

Diagnoses: Vaginitis - noninfectious
 Plan (include RX changes): *abx* *PPCR* *Vag*

Plan (include RX changes): *PPCR* *abx* *Vag*

Diet DAP VC Rest

600 Cal (Thyroid) Dose 200 mg T4 in AM & PM 70° F

coc. (heroin, LFT) TSH Mammogram annual

Hypothyroid, Uterus, Vag

EDUCATION

- [] Diet Modification: diabetes, heart disease, weight control, liver failure, renal failure
- [] Accident prevention: safety helmet, DUI, guns, violent behavior, seat belts
- [] Guidance: Smoking, alcohol, marijuana, cocaine, IV and other drugs, suicidal ideation, puberty progress, sex education (partner selection, condoms, contraception, AIDS risk factors), goals in life?
- [] Other advice: _____
- [] Mammogram ordered [] Mammogram done

Next appointment: *Thru Jan* Signature *J. J. DeRosa*

Date 4/8/13

Marian Jalil, M.D., Inc.

PATIENT PROGRESS NOTE

Patient Name De Lakoussayl Reina Practitioner _____
 M F DOB 12/29/86 Age 27
 Allergies (See Problem List)

Reason for Visit:

C/o BACK PAIN X 3 days moving furniture**SUBJECTIVE**

WT 254 HT 5'11" BP _____ Temp _____ P _____ R _____ LMP _____

BMI: 35 Date & Results of Most Recent: HbA1C: _____ / _____ LDL: _____ / _____ See DM Flowsheet

Microalbumin: _____ / _____ Date of DM Retinal Exam: _____ Eye exam report on Chart: Yes No

(Check) Systems Examined See Foot Exam form (reverse side)

- N Ab
- Gen. App
- Skin
- Eyes
- Ears
- Nose
- Throat
- Neck
- Heart
- Chest / Lungs
- Breast
- Abd.
- Vaginal / Cervix
- Bimanual
- Rectal
- GU / Prostate
- Back
- Ext.
- Neuro

OBJECTIVE

Diagnosis:

Patient Education:

- Advance Directive DM Patient Action Plan
- Diabetes Safety
- Diet Seat Belt
- ETOH Self Breast Exam
- Exercise Self Testicle Exam
- STD Stress Management
- Wound Care Smoking/Tobacco Cessation
- DM Pocket Card Medication Side Effects
- Other _____

ASSESSMENT**Order:**

- Basic Metabolic Panel HbA1C
- Complex Metabolic Panel CBC Complete*
- Lipid Panel Urinalysis
- Microalbumin urine Pneumonia/Flu Vaccine

*Diagnosis must support need for testing

Other:Referrals: DM Mgmt. Class (Health ED)
 DM Retinal Exam _____**Return Visit:**

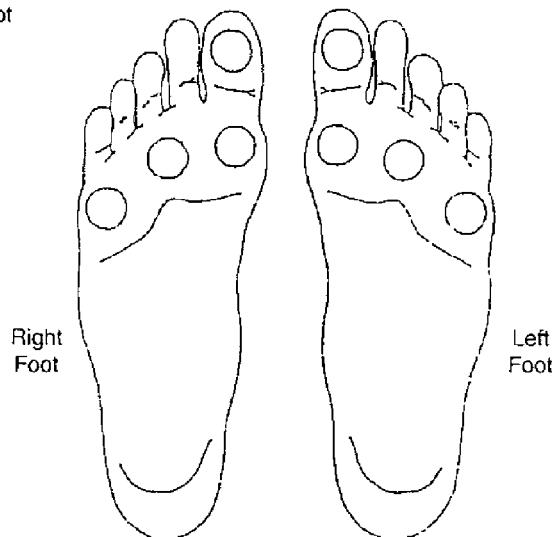
_____ Days if not well

_____ weeks/months for _____
 (circle)**PLAN****Practitioner's Signature:**Check M.D. D.O. P.A. N.P.

Diabetes Foot Screening

Fill in the following blanks with "Y" or "N" to indicate findings on the right or left foot

	R	L
Is there a foot ulcer now?	_____	_____
Is there a history of foot ulcers?	_____	_____
Is there an abnormal shape of the foot?	_____	_____
Is there toe deformity?	_____	_____
Are the toenails thick or ingrown?	_____	_____
Is there callus buildup?	_____	_____
Is there swelling?	_____	_____
Is there elevated skin temperature?	_____	_____
Is there muscle weakness?	_____	_____
Are the pedal pulses intact & symmetric?	_____	_____
Can the patient see the bottom of his/her feet?	_____	_____
Is the patient wearing improperly fitting shoes?	_____	_____
Does the patient use footwear appropriate for his/her category?	_____	_____



Indicate the level of sensation in the circles:

- + = Can feel the 10 gram nylon filament
- = Cannot feel the 10 gram nylon filament

Skin Conditions on the foot and between the toes:

1 – Draw pattern where there is: Callus Pre-Ulcer Ulcer (note the ulcer size in cm.)

2 – Label skin conditions with: R – Redness S – Swelling W – Warmth D – Dryness and/or M – Maceration

RISK CATEGORY

- 0 – No loss of protective sensation
- 1 – Loss of protective sensation with weakness, deformity, callus, pre-ulcer or history of ulceration.
- 2 – Loss of protective sensation with weakness, deformity, pre-ulcer or callus by not history of ulceration or poor circulation.
- 3 – History of plantar ulceration or neuropathic fracture.

10-3-12

Marian Jalil, M.D., Inc.

JENNIFER CARBAJAL

PATIENT PROGRESS NOTEdate

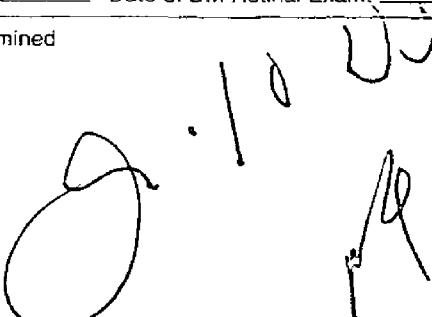
Patient Name

Dela Hueso, Reina

Practitioner

 M F DOB _____ Age _____

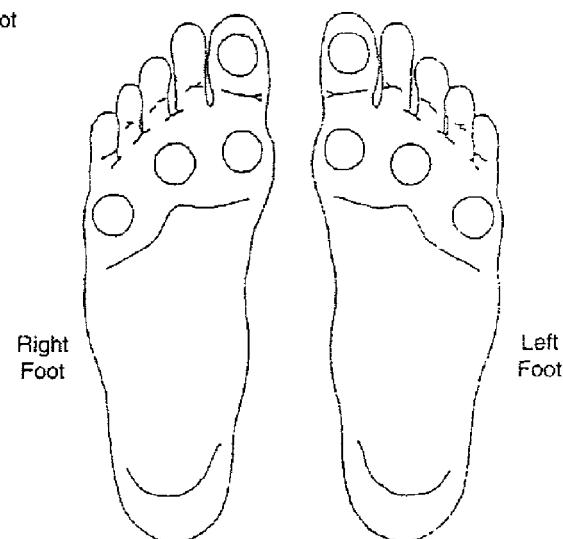
Allergies (See Problem List)

SUBJECTIVE	Reason for Visit: _____ _____	
	WT _____ HT _____ BP _____ Temp _____ P _____ R _____ LMP _____ BMI: _____ Date & Results of Most Recent: HbA1C: _____ / _____ LDL: _____ / _____ <input type="checkbox"/> See DM Flowsheet Microalbumin: _____ / _____ Date of DM Retinal Exam: _____ Eye exam report on Chart: <input type="checkbox"/> Yes <input type="checkbox"/> No	
OBJECTIVE	(Check) ✓ Systems Examined N Ab <input type="checkbox"/> Gen. App <input type="checkbox"/> Skin <input type="checkbox"/> Eyes <input type="checkbox"/> Ears <input type="checkbox"/> Nose <input type="checkbox"/> Throat <input type="checkbox"/> Neck <input type="checkbox"/> Heart <input type="checkbox"/> Chest / Lungs <input type="checkbox"/> Breast <input type="checkbox"/> Abd. <input type="checkbox"/> Vaginal / Cervix <input type="checkbox"/> Bimanual <input type="checkbox"/> Rectal <input type="checkbox"/> GU / Prostate <input type="checkbox"/> Back <input type="checkbox"/> Ext. <input type="checkbox"/> Neuro	<input type="checkbox"/> See Foot Exam form (reverse side)
		
ASSESSMENT	Diagnosis: _____ _____	Patient Education: <input type="checkbox"/> Advance Directive <input type="checkbox"/> DM Patient Action Plan <input type="checkbox"/> Diabetes <input type="checkbox"/> Safety <input type="checkbox"/> Diet <input type="checkbox"/> Seat Belt <input type="checkbox"/> ETOH <input type="checkbox"/> Self Breast Exam <input type="checkbox"/> Exercise <input type="checkbox"/> Self Testicle Exam <input type="checkbox"/> STD <input type="checkbox"/> Stress Management <input type="checkbox"/> Wound Care <input type="checkbox"/> Smoking/Tobacco Cessation <input type="checkbox"/> DM Pocket Card <input type="checkbox"/> Medication Side Effects <input type="checkbox"/> Other _____ _____ _____
	Order: <input type="checkbox"/> Basic Metabolic Panel <input type="checkbox"/> HbA1C <input type="checkbox"/> Complex Metabolic Panel <input type="checkbox"/> CBC Complete* <input type="checkbox"/> Lipid Panel <input type="checkbox"/> Urinalysis <input type="checkbox"/> Microalbumin urine <input type="checkbox"/> Pneumonia/Flu Vaccine *Diagnosis must support need for testing Other: _____	Return Visit: _____ Days if not well _____ weeks/months for _____ (circle)
PLAN	Referrals: <input type="checkbox"/> DM Mgmt. Class (Health ED) <input type="checkbox"/> DM Retinal Exam _____	Practitioner's Signature: <input type="checkbox"/> Check ✓ <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> P.A. <input type="checkbox"/> N.P.

Diabetes Foot Screening

Fill in the following blanks with "Y" or "N" to indicate findings on the right or left foot

	R	L
If there a foot ulcer now?	_____	_____
Is there a history of foot ulcers?	_____	_____
Is there an abnormal shape of the foot?	_____	_____
Is there toe deformity?	_____	_____
Are the toenails thick or ingrown?	_____	_____
Is there callus buildup?	_____	_____
Is there swelling?	_____	_____
Is there elevated skin temperature?	_____	_____
Is there muscle weakness?	_____	_____
Are the pedal pulses intact & symmetric?	_____	_____
Can the patient see the bottom of his/her feet?	_____	_____
Is the patient wearing improperly fitting shoes?	_____	_____
Does the patient use footwear appropriate for his/her category?	_____	_____



Indicate the level of sensation in the circles:

+ = Can feel the 10 gram nylon filament
- = Cannot feel the 10 gram nylon filament

Skin Conditions on the foot and between the toes:

- 1 – Draw pattern where there is: Callus Pre-Ulcer Ulcer (note the ulcer size in cm.)
 2 – Label skin conditions with: R – Redness S – Swelling W – Warmth D – Dryness and/or M – Maceration

RISK CATEGORY

- | |
|--|
| 0 – No loss of protective sensation |
| 1 – Loss of protective sensation with weakness, deformity, callus, pre-ulcer or history of ulceration. |
| 2 – Loss of protective sensation with weakness, deformity, pre-ulcer or callus by not history of ulceration or poor circulation. |
| 3 – History of plantar ulceration or neuropathic fracture. |

PROGRESS NOTES

PATIENT NAME:		<i>De lahoussay Pene</i> D. O. B <u>12/29/86</u>		
DATE	11	ALLERGY	PHYSICAL	
TEMP.			N	ABN
PULSE		CURRENT MEDICATION(S):	H.E.E.N.T.	
RESP.			NECK	
B/P			CHEST	
WEIGHT			BREAST	
HEIGHT			HEART	
AGE			LUNGS	
CHIEF COMPLAINT(S):		<i>Chylothorax</i> <i>Conjunctivitis</i> <i>Conjunctivitis</i>		
OBJECTIVE:		ABN SEE NOTES		
DIAGNOSIS:		PARK REGENCY <i>714-773-0750</i> <i>562-691-8810</i>		
PLAN:		OTHERS FLU VACCINE PNEUMOVACCINE		
SIGNATURE:		M.D. RETURN TO OFFICE: _____		
		MARIAN JALIL, M. D.		

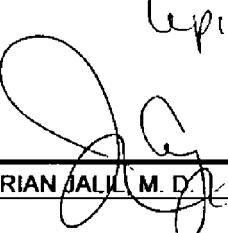
DRJ-102

PROGRESS NOTES

PATIENT NAME: Dela Hassan, Romeo D.O.B. 12/29/86

DATE	2/23/11	ALLERGY	PHYSICAL	N	ABN
TEMP.		CURRENT MEDICATION(S):	H.E.E.N.T.	<input checked="" type="checkbox"/>	
PULSE	76		NECK	<input checked="" type="checkbox"/>	
RESP.	18		CHEST	<input checked="" type="checkbox"/>	
B/P	90/60		BREAST	<input checked="" type="checkbox"/>	
WEIGHT	250	See List	HEART	<input checked="" type="checkbox"/>	
HEIGHT	220		LUNGS	<input checked="" type="checkbox"/>	
AGE	21		ABDOMEN	<input checked="" type="checkbox"/>	
CHIEF COMPLAINT(S):	Here for a cold Sore throat				
	lost 100lb. since Oct 15th.				
	∅ meds for DM.				
OBJECTIVE:	WT 140lb HT 5'10" Vital signs				
DIAGNOSIS:	PT. EDUC.				
	ACTIVITY:				
	DIET/WT.				
	MEDS.				
	OTHERS				
PLAN:	Diabetic education Classmate PH Obesity				
	FLU VACCINE				
	PNEUMOVACCINE				

Cx. Chem, ~~Thyroid~~ thyroid vacasity. SC/INJ,
lipid panel

SIGNATURE: 

M.D. RETURN TO OFFICE:

MARIAN JALI, M.D.

DRJ-102

PROGRESS NOTES

PATIENT NAME: Dolahassayey Reyno D. O. B.

DATE 6-9-10	ALLERGY	PHYSICAL	
TEMP.		N	ABN
PULSE	CURRENT MEDICATION(S):	H.E.E.N.T.	
RESP.		NECK	
B/P		CHEST	
WEIGHT		BREAST	
HEIGHT		HEART	
AGE		LUNGS	
CHIEF COMPLAINT(S): <i>Chronic pain</i>		ABDOMEN	
		GENITAL	
		PELVIC	
		RECTAL	
		PROSTATE	
		SPINE	
		EXTREM.	
		NEURO.	
		MENTAL	
		ABN SEE NOTES	
		PT. EDUC.	
		ACTIVITY:	
		DIET/WT.	
		MEDS.	
Doctor's Signature: <i>Clark M. Jalil, M.D.</i>		OTHERS	
Clerk or House Officer:			
PLAN:		FLU VACCINE	
		PNEUMOVACCINE	

SIGNATURE:

M.D. RETURN TO OFFICE:

MARIAN JALIL, M. D.

DRJ-102

PROGRESS NOTES

PATIENT NAME: Melahassay Pedro B.

DATE	6/10	ALLERGY	PHYSICAL	
TEMP.			N	ABN
PULSE		CURRENT MEDICATION(S):	H.E.E.N.T.	
RESP.			NECK	
B/P			CHEST	
WEIGHT			BREAST	
HEIGHT			HEART	
AGE	Date:		LUNGS	
CHIEF COMPLAINT(S):	1. Coughed..... New Age right side		ABDOMEN	
	2. Felted to know Follow up		GENITAL	
	a. Not bad		PELVIC	
OBJECTIVE:	b. Tumor	Cont.	RECTAL	
	c. Phono	Normal	PROSTATE	
	Tumor in right side		SPINE	
DIAGNOSIS:	Dermatoma		EXTREM.	
	Cough in right side		NEURO.	
	Tumor in right side		MENTAL	
	Dermatoma		ABN SEE NOTES	
			PT. EDUC.	
			ACTIVITY:	
			DIET/WT.	
			MEDS.	
			OTHERS	
PLAN:			FLU VACCINE	
			PNEUMOVACCINE	

SIGNATURE:

M.D. RETURN TO OFFICE:

MARIAN JALIL, M. D.

PROGRESS NOTES

PATIENT NAME: Dela noussayl Reino D. O. B.

DATE <u>3/10</u>	ALLERGY	PHYSICAL	N	ABN
TEMP.		H.E.E.N.T.		
PULSE	CURRENT MEDICATION(S):	NECK		
RESP.		CHEST		
B/P		BREAST		
WEIGHT		HEART		
HEIGHT		LUNGS		
AGE		ABDOMEN		
CHIEF COMPLAINT(S):		GENITAL		
		PELVIC		
		RECTAL		
		PROSTATE		
		SPINE		
		EXTREM.		
		NEURO.		
		MENTAL		
		ABN SEE NOTES		
		PT. EDUC.		
		ACTIVITY:		
DIAGNOSIS:		DIET/WT.		
		MEDS.		
		OTHERS		
PLAN:		FLU VACCINE		
		PNEUMOVACCINE		

SIGNATURE: M.D. RETURN TO OFFICE:

MARIAN JALIL, M. D.

- STEP 1: General Information**
- Answer the following questions by completely filling in the appropriate blue or black ink.
- YES NO
- I am a citizen of the United States.....
If NO, I am a citizen of: _____
Alien Reg. # _____
 - I am able to read and understand basic English.....
If NO, the language spoken in my household is: _____
 - I am a resident of the County of Los Angeles.....
(If No, place New Address in "Section F" and see Section H")
 - I am at least 18 years of age or older.....
 - I am now serving as a grand or trial juror in a court of this state.....

- YES NO
- I have been convicted of a felony or malfeasance in office (If NO, skip questions 6A. below).....
 - If you have a felony conviction, have your rights been restored by a pardon or has your conviction been expunged under PC § 17, § 1203.4, or 1203.4a?.....
 - I am under a court-appointed conservatorship.....
 - I am on active military duty and/or not domiciled in this state.....
- EXEMPTION:**
- I am a peace officer appointed under PC 830.1 or 830.2(a) or 830.33(a).....

**STEP 2: Sign and Date Unsigned
Form is not valid without a signature.**

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.
(CCP Sec. 2015.5 (b)). X _____ Date _____

*****SIGN And Date HERE*****

Juror Name: _____ **Age:** _____
Telephone: Home () _____ Work () _____
Occupation: _____ Student Retired
 Homemaker Unemployed Government Employee
Employer: _____

Employer Address: _____
City: _____ **State:** _____ **Zip:** _____
Employer Pays for: _____ **Days of Jury Service:** _____
Emergency Contact: _____ **Relationship:** _____ **Phone:** () _____

Check here if your name or address has changed. (Legal documentation is required as proof for a name change.)

STEP 4 - Register By Telephone Call: 1-800-778-5879 (1-800-SRV-JURY)

The telephone system will guide you through the process. You will need your Juror I.D. and Pin No.
 NOTE: You must register by telephone or you cannot request a Postponement, Transfer, or Excuse from Jury Service.

Juror I.D. NO. 082771599
PIN NO. 9579

Only Complete the Sections below if instructed to do so by the telephone center during registration.

Section B REQUEST TO BE: EXCUSED TRANSFERRED

(location change)

Excuse and Transfer requests must be in writing. Sign and date Section G below.

- Physical or mental incapacity. (If under 70 years of age, a physician must complete Section E, if over 70 explain the medical reason in Section D).
- I have a personal obligation to provide full time care for another from the hours of 8 a.m. and 5 p.m., Mon.-Fri. State relationship to dependent, age(s) and type of care provided in Section D.
- I have no reasonable means of transportation to the court location that has summoned me.
- I have served as a trial juror or grand juror in the past 12 months.
month: _____ Location: _____
- Other reason. Please explain reason in Section D. Full-time student status, occupation as a teacher, and age do not qualify for excuse. Service can be scheduled to a more convenient time. Breast feeding a child will qualify for postponement of service.

Section C FINANCIAL HARSHIP (Failure to properly explain may cause automatic qualification for jury service.)

- Extreme financial burden or serious economic injury.
ALL the questions MUST be answered in the FINANCIAL HARSHIP EVALUATION below.

FINANCIAL HARSHIP EVALUATION

Number of Persons _____ (Adults _____ Minors _____) (In my household)
(including yourself) (dependents)

Total Yearly Income of all individuals in my household before taxes \$ _____
(including Social Security Payments, Alimony, Child Support, Retirement Benefits, etc.)
Monthly Household Expenses \$ _____

EXPLAIN REASON(S) FOR EXCUSE or TRANSFER HERE (If over 70 years of age, explain medical reason for "not serving").

Section D

Section E MEDICAL EXCUSE / TRANSFER (If under 70 years of age, a physician must complete Section E, if over 70 use Section D)

MEDICAL RELEASE I hereby authorize my physician to release my medical information as pertinent. Addressee Signature: X _____

PHYSICIAN STATEMENT Some medical problems do not warrant an excuse from service or a postponement. For any excuse that you provide, please be aware that you will be called to testify before the Court about your representations regarding your patient's health. ALL questions must be answered. If not, then this application is considered incomplete and invalid, and the request for excuse denied.

Is patient homebound / bed bound? Yes No
 If yes, how long will condition remain? N/A
 Current Diagnosis: Diabetes Mellitus, Obesity, Type 2
 Prognosis: fair out of control
 Is patient employed? Yes No
 When will patient be well enough to serve? 6 months month(s).
 List any consultant(s) and their specialty used to verify or treat patient:
 Phone: _____

Physician's Name: Richard J. Trujillo
 Address: 14350 E. Whalley Dr. Suite 200
 Specialty: Med. Lic. # 56789 Med. Lic. # 56789

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. (CCP Sec. 2015.5(b))

X

Physician's Signature

Date: 9/30/07

16. Change of Address: _____

Signature of Respondent X _____ Date _____

Section F

Section G It is perjury to falsify an excuse from jury service. Perjury is a felony punishable by up to four years in state prison (§ sec. 126). I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct (CCP sec. 2015-5(b)).

Sign & Date X

JURORS REQUESTING AN EXCUSE OR TRANSFER MUST SIGN AND DATE THE FORM

PROGRESS NOTES

PATIENT NAME: DeLoach, Irene D.O.B.: 10/10/08

DATE	ALLERGY:	PHYSICAL		
TEMP.		N	ABN	
PULSE	CURRENT MEDICATION(S):	H.E.E.N.T.		
RESP.		NECK		
B/P		CHEST		
WEIGHT		BREAST		
HEIGHT		HEART		
AGE		LUNGS		
		ABDOMEN		
CHIEF COMPLAINT(S):		GENITAL		
		PELVIC		
		RECTAL		
		PROSTATE		
		SPINE		
		EXTREM.		
		NEURO.		
OBJECTIVE:		MENTAL		
		ABN SEE NOTES		
		PT. EDUC.		
		ACTIVITY		
DIAGNOSIS:		DIET/WT		
		MEDS.		
		OTHERS		
PLAN:		FLU VACCINE		
		PNEUMOVACCINE		
SIGNATURE: _____ M.D. RETURN TO OFFICE: _____				
MARIAN JALIL M.D.				

PROGRESS NOTES

PATIENT NAME: Rita Housayeline D.O.B.: _____

DATE	ALLERGY:	PHYSICAL	
TEMP.		N	ABN
PULSE	CURRENT MEDICATION(S):	H.E.E.N.T.	
RESP.		NECK	
B/P		CHEST	
WEIGHT		BREAST	
HEIGHT		HEART	
AGE		LUNGS	
CHIEF COMPLAINT(S): <i>No show</i>		ABDOMEN	
		GENITAL	
		PELVIC	
		RECTAL	
		PROSTATE	
		SPINE	
		EXTREM.	
		NEURO.	
OBJECTIVE:		MENTAL	
		ABN SEE NOTES	
		PT. EDUC.	
		ACTIVITY	
DIAGNOSIS:		DIET/WT.	
		MEDS.	
PLAN:		<i>Pt needs to come to office No more refills 12/2017</i>	
SIGNATURE:		<u>MARIAN JALIL M.D.</u>	
RETURN TO OFFICE:			



PROGRESS NOTES

PATIENT NAME: <u>Velashoway</u> ^{Reco} D.O.B.: _____			
DATE <u>10-24-00</u>	ALLERGY: _____	PHYSICAL	
TEMP.		H.E.E.N.T.	N
PULSE	CURRENT MEDICATION(S): <u>Chantix 10 mg</u>	NECK	ABN
RESP.		CHEST	
B/P		BREAST	
WEIGHT		HEART	
HEIGHT		LUNGS	
AGE		ABDOMEN	
CHIEF COMPLAINT(S): <u>Chantix 10 mg</u>		GENITAL	
		PELVIC	
		RECTAL	
		PROSTATE	
		SPINE	
		EXTREM.	
		NEURO.	
OBJECTIVE:		MENTAL	
		ABN SEE NOTES	
		PT. EDUC.	
		ACTIVITY	
DIAGNOSIS:		DIET/WT.	
		MEDS.	
		OTHERS	
PLAN:		FLU VACCINE	
		PNEUMOVACCINE	
SIGNATURE: _____ M.D. RETURN TO OFFICE: _____			
MARIAN JALIL M.D.			

PROGRESS NOTES

PATIENT NAME: <u>Delashaway</u>		D.O.B.: <u>12/29/86</u>			
DATE <u>10/16/16</u>	ALLERGY: <u>None</u>	PHYSICAL N ABN			
TEMP. <u>97</u>	PULSE <u>72</u>	CURRENT MEDICATION(S): <u>See List</u>	H.E.E.N.T.	<u>(R) m/c</u>	<u>Lundmarks distal</u>
RESP. <u>18</u>	B/P <u>130/100</u>		NECK	<u>(R) m/c</u>	
WEIGHT <u>295</u>	HEIGHT <u>5'9"</u>		CHEST	<u>(R) m/c</u>	
AGE <u>31</u>			BREAST		
CHIEF COMPLAINT(S): <u>Here for back pain and medication refill Back pain</u>			HEART	<u>L</u>	
			LUNGS	<u>L</u>	
			ABDOMEN		
			GENITAL		
			PELVIC		
			RECTAL		
			PROSTATE		
			SPINE		<u>-OCUAT</u>
			EXTREM.		
			NEURO.		
			MENTAL		
			ABN SEE NOTES		
OBJECTIVE: <u>Wt: 295 - exp. had back strain never came back. pt said didn't "want want." - glucomax upset stomach. No insulin to come but/ hosp gave glipizide. Seems to really need BS.</u>			PT. EDUC.		
DIAGNOSIS: <u>A trig / chd TDM poor control Poor compliance LBP</u>			ACTIVITY		
			DIET/WT.		<u>extention</u>
			MEDS.		<u>ext and diet</u>
			OTHERS		<u>on consult</u>
PLAN: <u>CBG, Chemode, LFT, HbA1c, UA - visit inclu done glipizide 5 mg i OD</u>			FLU VACCINE		
			PNEUMOVACCINE		
SIGNATURE: <u>Marian Alil M.D.</u>		M.D.	RETURN TO OFFICE:	<u>2 wks.</u>	

PROGRESS NOTES

PATIENT NAME: <u>De La Houssay Reine</u>		D.O.B.: _____		
DATE <u>10/11/06</u>	ALLERGY: _____	PHYSICAL		
TEMP. _____				N _____ ABN _____
PULSE _____	CURRENT MEDICATION(S): _____	H.E.E.N.T. _____		
RESP. _____				NECK _____
B/P _____				CHEST _____
WEIGHT _____				BREAST _____
HEIGHT _____				HEART _____
AGE _____				LUNGS _____
CHIEF COMPLAINT(S): _____ _____ _____		ABDOMEN _____ GENITAL _____		
OBJECTIVE: _____ _____ _____		TE _____ _____		
DIAGNOSIS: _____ _____ _____		NOTES _____ _____		
www.oxytrol.com		1.888.OXYTROL _____		
		MEDS. <i>10/09/06</i> <i>10/09/06</i>		
		OTHERS <i>check</i> <i>check</i>		
PLAN: _____ _____ _____		FLU VACCINE _____ PNEUMOVACCINE _____		
SIGNATURE: _____ M.D.		RETURN TO OFFICE: _____		
MARIAN JALIL M.D.				

PROGRESS NOTES

PATIENT NAME: <u>Delahousse</u> ^{Rome}		D.O.B.: _____
DATE <u>9/13/06</u>	ALLERGY: _____	PHYSICAL
TEMP.		N
PULSE	CURRENT MEDICATION(S): _____	H.E.E.N.T.
RESP.		NECK
B/P		CHEST
WEIGHT		BREAST
HEIGHT		HEART
AGE		LUNGS
CHIEF COMPLAINT(S): <i>(Handwritten notes)</i>		ABDOMEN
		GENITAL
		PELVIC
		RECTAL
		PROSTATE
		SPINE
		EXTREM.
		NEURO.
OBJECTIVE:		MENTAL
		ABN SEE NOTES
		PT. EDUC.
DIAGNOSIS:		ACTIVITY
		DIET/WT.
		MEDS.
		OTHERS
PLAN:	FLU VACCINE	
	PNEUMOVACCINE	
SIGNATURE: _____	M.D. RETURN TO OFFICE: _____	
MARIAN JALIL M.D.		

NETWORK MEDICAL MANAGEMENT, INC

STATEMENT FOR PROVIDER: This form is for requested services only. Further care must be authorized before it is rendered. If additional treatment is required please contact the referring physician. Payment will not be made for services, which have not been authorized. If you have any questions please contact the referring physician. Additionally, consultants findings and recommendations must be sent to the referring physician.

MEDICAL GROUP (Circle One) & Fax Number:

APC URGENTS/ER (626) 943-6387	LAMC (626) 943-6396
APC ROUTINE (626) 943-6367	MABU (626) 943-6397
ADV (626) 442-1106	MID-CITIES (562) 866-6454
APO (626) 943-6390	VH (626) 943-6399
AMERIWEST (626) 943-6392	SUB IPA URGENT/ER
GOM (909) 595-5867	(626) 943-6385
GSGP (626) 943-6394	

REFERRAL REQUESTED DATE: 4/21/04

(Circle One): **ROUTINE** **URGENT** **EMERGENCY**
 (5 days) (72 hours) (2-4 hours)

RETRO **STANDING**
 (30 days) (5 days)

Co - pay: \$ _____

PATIENT INFORMATION: TO AVOID DELAY COMPLETION OF THIS SECTION IS MANDATORY

Patient Name: Last Delahousse, First Reina, Middle _____ DOB 12/29/84 AGE _____ Sex: (M) Female
 Address: 1441 D Fedford Dr. City: Whittier Zip 90604 Phone # (323) 777-7414
 Health Plan Health Net (COM) (SNR) (HF) (AIM) (Medi-Cal) HMO Member ID # 60328588510SS#
 Member Effective Date 4/1/04 PCP Dr. Jilal Phone # (323) 945-7671 Fax (323) 945-7485
 Referring Provider Name: Marian Jilal Referred to Specialty: Diabetic education class
 M.D. Office Contact Name (Person filling out form): Lily 1ST Available or Provider Name: _____
 Phone # () _____ - _____ Fax # () _____ - _____ Phone # () _____ - _____ Fax # () _____ - _____

DIRECT REFERRALS ONLY: (CHECK ONE) ANY FOLLOW VISITS OR PROCEDURES MUST BE PRE-AUTHORIZED.

- Well Woman Exam - 99385 (age 18-39) 99386 (age 40-69) 99396 (age 71 and over) Pregnant OB Care (full term) - 59400
 Mammography - 76092 (40 - 50 years eligible every 2 years) Chest, Long Bone or KUB X- Rays (indicate CPT) _____
 Specialty Consultation (Initial Consultation, 99242 Only) Please Specify Specialty: _____

This section must be reviewed & signed by physicians prior to submission. TO AVOID DELAY COMPLETION OF THIS SECTION IS MANDATORY.

DIAGNOSIS: New onset ICD 250.0, DM 0a ICD _____ 3 ICD _____

Clinical Justification: Complete the following Information or ATTACH current H & P, Office Notes.

Clinical Symptoms and duration:

Physical Findings:

UM 7/7 to call back reas auth

Medication tried:

and Ins change 7/7

****Attach Labs, X-rays and/or consultation reports if applicable****Procedure/Service Requested****CPT Code****IPA Approved CPT Code**

<u>Diabetic education</u>	<u>99078 till thru daily</u>
<u>CVS</u>	<u>7/19/04</u>

Services To Be Provided At:

Physician Signature: JW

Date Of Service: _____

Date: _____

*SPECIALISTS: THE PCP'S MUST RECEIVE A COPY OF YOUR EVALUATION, TREATMENT PLAN AND OUTCOME WITHIN 48 HOURS SO THEY ARE BETTER ABLE TO FOLLOW THEIR PATIENTS PROGRESS.

FOR USE BY NETWORK MEDICAL MANAGEMENT ONLY

Authorized/Modified UM Signature: _____ Date: ____ / ____ / ____

Pended Date: ____ / ____ / ____ Pended Reason: _____

Denied Reason: _____ Date: ____ / ____ / ____

Date PCP Notified: ____ / ____ / ____ Date Specialist Notified: ____ / ____ / ____

AUTH #: _____

Response Date: ____ / ____ / ____ Signature: _____

UM Signature: _____

Member Notification: ____ / ____ / ____ by United States Mail

Authorization does not guarantee payments: All claims are subject to Eligibility, Contracted provisions and Exclusions. This certificate is good for 60 days from approval day. All Lab work and Imaging studies should be done at a Network Medical Management contracted facility.

UM decisions are based on standardized criteria. Provider may view criteria upon request. Call 626-282-0288 for more information.

Effective Date: 6-29-04

NETWORK MEDICAL MANAGEMENT, INC

STATEMENT FOR PROVIDER: This form is for requested services only. Further care must be authorized before it is rendered. If additional treatment is required please contact the referring physician. Payment will not be made for services, which have not been authorized. If you have any questions please contact the referring physician. Additionally, consultants findings and recommendations must be sent to the referring physician.

MEDICAL GROUP (Circle One) & Fax Number:

APC URGENTS/ER (626) 943-6387	LAMC (626) 943-6396
APC ROUTINE (626) 943-6387	MABU (626) 943-6397
ADV (626) 442-1106	MID-CITIES (562) 866-6454
APO (626) 943-6390	VII (626) 943-6399
AMERIWEST (626) 943-6392	SUB IPA URGENT/ER (626) 943-6385
GOM (909) 595-5867	
GSGP (626) 943-6394	

REFERRAL REQUESTED DATE: 4/21/04

(Circle One): **ROUTINE** **URGENT** **EMERGENCY**

(5 days) (72 hours) (2-4 hours)

RETRO **STANDING**

(30 days) (5 days)

Co - pay: \$ _____

PATIENT INFORMATION: TO AVOID DELAY COMPLETION OF THIS SECTION IS MANDATORY

Patient Name: Last DeGhousse First Reina Middle _____ DOB 12/29/81 AGE _____ Sex: (M)

Address: 14410 Tedrod Dr City: Whittier Zip 90604 Phone # (323) 777-7414

Health Plan Health Net (COM) (SNR) (HF) (AIM) (Medi-Cal) HMO Member ID # 603-285-885-01 SS # _____

Member Effective Date 4/1/04 PCP DR. JALIL Phone # 52945-7611 Fax 905-7485

Referring Provider Name: Marian Jalil Referred to Specialty: Endocrinology

M.D. Office Contact Name (Person filling out form): _____ 1ST Available or Provider Name: _____

Phone # () _____ - _____ Fax # () _____ - _____ Phone # () _____ - _____ Fax # () _____ - _____

DIRECT REFERRALS ONLY: (CHECK ONE) ANY FOLLOW VISITS OR PROCEDURES MUST BE PRE-AUTHORIZED.

- Well Woman Exam - 99385 (age 18-39) 99386 (age 40-69) 99396 (age 71 and over) Pregnant OB Care (full term) - 59400
 Mammography - 76092 (40 - 50 years eligible every 2 years) Chest, Long Bone or KUB X-Rays (indicate CPT) _____
 Specialty Consultation (initial Consultation, 99242 Only) Please Specify Specialty: _____

This section must be reviewed & signed by physicians prior to submission. TO AVOID DELAY COMPLETION OF THIS SECTION IS MANDATORY.

DIAGNOSIS: New onset DM ICD 250.02 ICD 3 ICD 3

Clinical Justification: Complete the following information or ATTACH current H & P, Office Notes.

Clinical Symptoms and duration:

Physical Findings:

Medication tried:

****Attach Labs, X-rays and/or consultation reports if applicable**

Procedure/Service Requested	CPT Code	IPA Approved CPT Code
<u>CONSULT</u>	<u>99243</u>	

Services To Be Provided At:

Physician Signature: JW

Date Of Service:

Date: _____

***SPECIALISTS: THE PCP'S MUST RECEIVE A COPY OF YOUR EVALUATION, TREATMENT PLAN AND OUTCOME WITHIN 48 HOURS SO THEY ARE BETTER ABLE TO FOLLOW THEIR PATIENTS PROGRESS.**

FOR USE BY NETWORK MEDICAL MANAGEMENT ONLY

Authorized/Modified UM Signature: _____ Date: ____ / ____ / ____

Pended Date: ____ / ____ / ____ Pended Reason: _____

Denied Reason: _____ Date: ____ / ____ / ____

Date PCP Notified: ____ / ____ / ____ Date Specialist Notified: ____ / ____ / ____

AUTH #: _____

Response Date: ____ / ____ / ____ Signature: _____

UM Signature: _____

Member Notification: ____ / ____ / ____ by United States Mail

Authorization does not guarantee payments: All claims are subject to Eligibility, Contracted provisions and Exclusions. This certificate is good for 60 days from approval day. All Lab work and Imaging studies should be done at a Network Medical Management contracted facility.

UM decisions are based on standardized criteria. Provider may view criteria upon request. Call 626-282-0288 for more information.

Effective Date: 6-29-04

PROGRESS NOTES

PATIENT NAME: Reina Dela Dosa D.O.B.: 11/14/1986

DATE	4/18/06	ALLERGY:	PHYSICAL
TEMP.			N ABN
PULSE	<u>68</u>	CURRENT MEDICATION(S):	H.E.E.N.T.
RESP.			NECK
B/P	<u>110/80</u>		CHEST
WEIGHT	<u>109.5</u>		BREAST
HEIGHT			HEART
AGE	<u>20</u>		LUNGS
CHIEF COMPLAINT(S):	<u>CP following up and last visitable feverish and continue to take medication per first.</u>		
OBJECTIVE:	<u>Ischemic D.D. C. C/S to throat. Gastroesophageal reflux disease.</u>		
	ABN SEE NOTES		
	PT. EDUC.		
DIAGNOSIS:	<u>Obesity</u>		
	ACTIVITY		
	<u>No exercise</u>		
	DIET/WT		
	<u>No diet plan</u>		
	MEDS.		
	<u>Glucophage 1500 mg bid</u>		
	<u>Metformin 500 mg bid</u>		
	<u>Metformin 500 mg bid</u>		
	<u>Metformin 500 mg bid</u>		
	<u>Metformin 500 mg bid</u>		
PLAN:	<u>VHS at home ACHES</u>		
	FLU VACCINE		
	PNEUMOVACCINE		
SIGNATURE:	<u>M.D. RETURN TO OFFICE:</u>		
<u>MARIAM JALIL M.D.</u>			

PROGRESS NOTES

PATIENT NAME: DeLoach, Reg. D.O.B.: _____

DATE TEMP.	ALLERGY:	PHYSICAL		
		N	ABN	
PULSE	CURRENT MEDICATION(S): <i>Change PDD</i>			
RESP.	H.E.E.N.T.			
B/P	NECK			
WEIGHT	CHEST			
HEIGHT	BREAST			
AGE	HEART			
CHIEF COMPLAINT(S): <i>Vomited</i>	LUNGS			
	ABDOMEN			
	GENITAL			
	PELVIC			
	RECTAL			
	PROSTATE			
	SPINE			
	EXTREM.			
OBJECTIVE:	NEURO.			
	MENTAL			
	ABN SEE NOTES			
	PT. EDUC.			
	ACTIVITY			
DIAGNOSIS:	DIET/WT.			
	MEDS.			
	OTHERS			
PLAN:	FLU VACCINE			
	PNEUMOVACCINE			
SIGNATURE: _____ M.D. RETURN TO OFFICE: _____				
MARIAN JALIL M.D.				

PROGRESS NOTES

PATIENT NAME:

Reino Dela Posa

D.O.B.:

8/12/1986

DATE 9/18/06

ALLERGY:

PHYSICAL

TEMP.

98.1

H.E.E.N.T.

PULSE

68

NECK

RESP.

10/80

CHEST

B/P

110/80

BREAST

WEIGHT

179 lbs

HEART

HEIGHT

5'9"

LUNGS

AGE

20

ABDOMEN

CHIEF COMPLAINT(S):

GP follow up
and lab results

GENITAL

declined insulin - wants to
try medication first

PELVIC

OBJECTIVE:

Discuss w/ Dr. Jelil
OK to start Glucophage.

RECTAL

PROSTATE

SPINE

EXTREM.

NEURO.

MENTAL

ABN SEE NOTES

PT. EDUC.

Obesity

ACTIVITY

DIAGNOSIS:

Hypertension

DIET/WT

new metformin OOC

IMEDS.

metformin

Glucophage 1000 mg bid

metformin

PLAN:

VBS at home ACVHS

FLU VACCINE

Hypert.

PNEUMOVACCINE

Bring Blood glucose logs to next appt.

SIGNATURE:

MARIAN JALIL M.D.

return to clinic

3 wks recheck

PROGRESS NOTES

PATIENT NAME: Reina

D.O.B.: 12/29/82

DATE	ALLERGY:	PHYSICAL
TEMP.		N ABN
PULSE	CURRENT MEDICATION(S):	H.E.E.N.T. (L m/sq (R) m/c NECK pharynx m/l by s CHEST no rales or crackles. BREAST
RESP.		HEART
B/P		LUNGS
WEIGHT		ABDOMEN
HEIGHT		GENITAL
AGE		PELVIC
CHIEF COMPLAINT(S): <u>Go MD establishment</u> <u>yeast infect, head aches</u> <u>when eating. Migraine, cough</u> <u>hair loss, darker face.</u>		
OBJECTIVE:		
Has one infarct - G.M. Bradley DM		
Pt H history: Last medical visit a long time ago. Lab P 368 po age: ACTIVITY		
DIAGNOSIS: const sexually active per mom Mom says in U.S.		
DIET/WT.		
MEDS.		
— Obesity		
— (R) otitis media		
— sinusitis		
— acne		
— vaginitis by history		
OTHERS		
PLAN: CBC. Panel, lipid panel, B/H Dryptin, UA, Pan. will discuss acn and at next visit		
FLU VACCINE		
PNEUMOVACCINE		
SIGNATURE: <u>M. J. Jalil, M.D.</u> M.D. RETURN TO OFFICE: <u>1 W/C</u> PA CPE		
MARIAN JALIL M.D.		

Agree
Diabetic teaching
endocrinologist
Insulin 70/30 20 units BID
glucosidase
P.S. 1/3/2011

ADVANCE DIRECTIVE ACKNOWLEDGMENT

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN INFORMED BY MY PHYSICIAN OF MY RIGHT TO EXECUTE AN ADVANCE DIRECTIVE FOR HEALTH CARE.

PLEASE READ & CHECK THE FOLLOWING STATEMENTS.

1- I HAVE EXECUTED AN ADVANCE DIRECTIVE.

--- YES --- NO

2- I HAVE BEEN GIVEN WRITTEN MATERIALS ABOUT MY RIGHTS.

--- YES --- NO

3 I WOULD LIKE TO RECEIVE ADDITIONAL INFORMATION REGARDING ADVANCE DIRECTIVES.

--- YES --- NO

4- I HAVE RECEIVED THE ADDITIONAL INFORMATION REGARDING ADVANCE DIRECTIVES.

--- YES --- NO

PATIENT INITIALS: R.D

PATIENT NAME: Reina Delattavaire

DOB: 12-29-86

MEDICAL RECORD NUMBER: _____

DATE: 4-16-08

HEALTH QUESTIONNAIRE

NAME Reina Delatourseyz
ADDRESS 16116 Tedford Dr.

AGE 19 DATE 4/10-06
PHONE 362-227-2414

HISTORY OF PAST ILLNESS: Have you had

Childhood:

Measles	<input checked="" type="checkbox"/> No	Yes
Mumps	<input checked="" type="checkbox"/> No	Yes
Chickenpox	No	<input checked="" type="checkbox"/> Yes
Diabetes	No	Yes
Stroke	No	Yes
Cancer	No	Yes

Rheumatic fever or heart disease	<input checked="" type="checkbox"/> No	Yes
Tuberculosis	<input checked="" type="checkbox"/> No	Yes
Venereal disease	<input checked="" type="checkbox"/> No	Yes
Congenital Abnormalities	<input checked="" type="checkbox"/> No	Yes
Other serious diseases:	<input checked="" type="checkbox"/> No	Yes

Adult:

Have you had any serious illness?
Have you ever been hospitalized or been under medical care for very long?
If yes, for what reason?

Operations:

Have you had any surgery? No Yes
List Tonsillectomy

Injuries:

Have you had any broken bones?
Have you had any head concussions or injuries?
Have you ever been knocked unconscious?

<u>FAMILY HISTORY:</u>	If Living:		If Deceased:		Has any blood relative ever had:
	Age	Health	Age (at death)	Cause	
Father					Cancer <input checked="" type="checkbox"/> No Yes
Mother					Tuberculosis <input checked="" type="checkbox"/> No Yes
Brother/Sister					Diabetes <input checked="" type="checkbox"/> No Yes
					Heart Trouble <input checked="" type="checkbox"/> No Yes
					High blood pressure <input checked="" type="checkbox"/> No Yes
					Stroke <input checked="" type="checkbox"/> No Yes
Husband/Wife					Convulsions <input checked="" type="checkbox"/> No Yes
Son/Daughter					Suicide <input checked="" type="checkbox"/> No Yes
					Insanity <input checked="" type="checkbox"/> No Yes
					Bleeding tendency <input checked="" type="checkbox"/> No Yes
					Gout or other arthritis <input checked="" type="checkbox"/> No Yes

SOCIAL HISTORY:

Circle One: Single Married Separated Divorced Widowed
 Are you living with your husband or wife? No Yes
 Is your sex life satisfactory? No Yes
 Do you have dependents at home? No Yes
 Alcoholic Beverages: Never Rarely _____ Moderately _____ Daily _____ Ever? _____
 Tobacco: Cigarettes _____ Packs a day _____ Don't Smoke _____ Ever smoked? _____
 Are you employed? Full Time _____ Part Time _____
 What is your job? CURRENTLY UN-EMPLOYED
 Are you exposed to fumes, dusts or solvents? NO

Education: _____ (Years)
 Grade School _____
 High School 04
 College _____
 Postgraduate _____

How much time have you lost from work because
of your health during the past?

Six Months WIA

One Year _____

Five Years _____

SYSTEMIC REVIEW: Do you have any of the following?

General:

Recent weight change? No Yes
 Have you been in good general health most of your life? No Yes

Skin:

Skin Disease No Yes
 Jaundice No Yes
 Hives, eczema or rash No Yes
 Frequent infection or boils No Yes
 Abnormal pigmentation No Yes

Head-Eyes-Ears-Nose-Throat:

Eye disease or injury No Yes
 Do you wear glasses? No Yes
 Double vision No Yes
 Headaches No Yes
 Glaucoma No Yes
 Itching eyes or nose No Yes

Head-Eyes-Ears-Nose-Throat (cont'd)

Sneezing or runny nose No Yes

Nosebleeds No Yes

Chronic sinus trouble No Yes

Ear disease No Yes

Impaired hearing No Yes

Dizziness or transient episodes of unconsciousness No Yes

Neck:

Stiffness No Yes

Thyroid trouble No Yes

Enlarged glands No Yes

Respiratory:

URI (cold) now No Yes

Spitting up blood No Yes

Chronic or frequent cough No Yes

SYSTEMIC REVIEW:

Respiratory (Cont'd)

Asthma or Wheezing	No
Difficulty breathing	Yes
Any trouble with lungs	No
Pleurisy or Pneumonia	Yes

Cardiovascular:

Chest pain or angina pectoris	No
Shortness of breath with walking or lying down	Yes
Difficulty walking two blocks	No
Heart trouble or heart attacks	Yes
High blood pressure	No
Swelling of hands, feet or ankles	Yes
Awakening in the night smothering	No
Heart murmur	Yes

Gastrointestinal:

Peptic ulcer (stomach or duodenal)	No
Vomiting blood or food	Yes
Gallbladder disease	No
Liver trouble	Yes
Hepatitis	No
Painful bowel movements	Yes
Bleeding with bowel movements	No
Black stools	Yes
Hemorrhoids or piles	No
Recent change in bowel habits	Yes
Frequent diarrhea	No
Heartburn or indigestion	Yes
Cramping or pain in the abdomen	No
Does food stick in throat	Yes

Genitourinary

Loss of urine	No
Frequent urination	Yes
Night time urinating	No
Burning or painful urination	Yes
Blood in urine	No
Kidney trouble	Yes
Kidney stones	No
Kidney Disease	Yes

Gynecological

Age periods started	19
How long do periods last?	5-6 d
Days	

Gynecological (cont'd)

Number of pregnancies	0
Number of miscarriages	0
Date of last cancer smear and results	Done
Last Mammogram done	
Frequency of periods, every days.	NA
Any pain with your periods	No
Number of children Ages	0
Date of first day of last period	7-23-04

Locomotor-Musculoskeletal:

Varicose veins	No
Weakness of muscles or joints	Yes
Any difficulty in walking	No
Any pain in calves or buttocks on walking relieved by rest	No

Neuro-Psychiatric:

Have you ever had psychiatric care?	No
Have you been advised to see a psychiatrist?	Yes
Do you ever have, or have had, fainting spells?	No
Convulsions	No
Paralysis	No

Hematologic:

Are you slow to heal after cuts	No
Blood disease	Yes
Anemia	No
Phlebitis	No
Have you had difficulty with bleeding excessively, after tooth extraction or surgery?	Yes
Have you had abnormal bruising or bleeding?	No

Allergic:

Any allergies, including medication	No
---	----

Endocrine

Thyroid disease	No
Hormone therapy	Yes
Any change in hot or glove size	No
Any change in hair growth	No
Have you become colder than before - or skin become dryer	Yes

HEIGHT 5'10

WEIGHT 72

ALLERGIES AND SENSITIVITIES

1. Is there a history of skin reaction or other untoward reaction or sickness following injection or oral administration of:

Penicillin or other antibiotics	Yes
Morphine, Codeine, Demerol or other narcotics	Yes
Novocain or other anesthetics	Yes
Aspirin, empirin or other pain remedies	Yes
Sulfa drugs	Yes
Tetanus antitoxin or other serums	Yes
Adhesive tape	Yes
Iodine or merthiolate	Yes
Any other drug or medication	Yes
Any foods, such as egg, milk or chocolate	Yes

Circle One

No	Don't know

What Drug or Food?

2. Drugs Recently Taken: Within the past six months has patient taken:

Cortisone	No
ACTH	No
Anticoagulants	No
Tranquillizers	No
Hypotensives (high blood pressure medicines)	No
Has the patient ever received treatment for: Asthma, rheumatism or rheumatic fever?	No
Aspirin	Yes

Don't know

Source of information, if other than patient: _____

Signature of person acquiring this information: _____

M. Jaiil

Doctor

4/10/04

Date

Pradee

Signature of patient



Dynamic Medical Imaging

406 S Beach Blvd # 106 Anaheim CA 92804 | 1110 W. La Palma Ave. #3 Anaheim, CA 92801
Tel: (714) 995-8471 Fax: (714) 995-5315 Tel: (714) 991-3367 Fax: (714) 772-2529
8135 Poinier Ave. #101 Whittier, CA 90602 | 959 N. Tustin Ave. #5 Santa Ana, CA 92705
Tel: (562) 789-9270 Fax: (562) 789-0484 Tel: (657) 232-1572 Fax: (657) 232-1581

Name: **DELAHOUSSAYE, REINA** Exam Date: **6/15/2016**
DOB: **12/29/1986** Age **29** Accession: **1338832**
MRN: **1115202** Exam: **HIP RIGHT**
Referring: **JALIL, MARIAN** Referring Fax: **5629457485**

RIGHT HIP AND AP PELVIS:

INDICATION: Hip pain.

FINDINGS: AP projection of the pelvis and frog-leg view of the right hip are obtained. There is no evidence of fracture or dislocation. Bony and joint spaces are essentially intact. No radiopaque foreign body is seen.

IMPRESSION:

Normal appearance of the right hip.

Reported By: LEE M.D., DANIEL Signed: 6/15/2016
E-Signed By: LEE M.D., DANIEL

Thank you for referring DELAHOUSSAYE, REINA to our Whittier office.



Patient Information		Specimen Information	Client Information	
DELA HOUSEY, BEINA		Specimen: EN304714K Requisition: 4011726	Client #: 76020042	MAIL0000
DOB: 12/29/1986	AGE: 30	Collected: 08/10/2017	JALIL, MARIAN	
Gender: NG	Fasting: U	Received: 08/10/2017 / 22:53 PDT	MARIAN JALIL, M.D.	
Phone: NG		Reported: 08/11/2017 / 10:50 PDT	14350 WHITTIER BLVD STE 200	
Patient ID: NG			WHITTIER, CA 90605-2148	

Test Name	In Range	Out Of Range	Reference Range	Lab
BASIC METABOLIC PANEL				
GLUCOSE		134 H	65-99 mg/dL	EN

Fasting reference interval

For someone without known diabetes, a glucose value >125 mg/dL indicates that they may have diabetes and this should be confirmed with a follow-up test.

UREA NITROGEN (BUN)	10	7-25 mg/dL
CREATININE	0.65	mg/dL

Age and/or gender not provided. Unable to calculate eGFR.

Reference Range
 Male: 0.60-1.35
 Female: 0.50-1.10
 Unable to flag appropriately due to gender not provided.

BUN/CREATININE RATIO	NOT APPLICABLE	6-22 (calc)
SODIUM	139	135-146 mmol/L
POTASSIUM	4.1	3.5-5.3 mmol/L
CHLORIDE	105	98-110 mmol/L
CARBON DIOXIDE	24	20-31 mmol/L
CALCIUM	9.8	mg/dL

Reference Range
 Male: 8.6-10.3
 Female: 8.6-10.2
 Unable to flag appropriately due to gender not provided.

HEMOGLOBIN A1C WITH MPG

HEMOGLOBIN A1c

For someone without known diabetes, a hemoglobin A1c value of 6.5% or greater indicates that they may have diabetes and this should be confirmed with a follow-up test.

For someone with known diabetes, a value <7% indicates that their diabetes is well controlled and a value greater than or equal to 7% indicates suboptimal control. A1c targets should be individualized based on duration of diabetes, age, comorbid conditions, and other considerations.

Currently, no consensus exists regarding use of hemoglobin A1c for diagnosis of diabetes for children.

MEAN PLASMA GLUCOSE	247	mg/dL (calc)
CBC (INCLUDES DIFF/PLT)		EN
WHITE BLOOD CELL COUNT	8.1	3.8-10.8 Thousand/uL

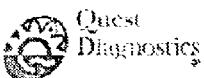


Patient Information		Specimen Information	Client Information
DELA HOUSEY, BEINA DOB: 12/29/1986 AGE: 30 Gender: NG Fasting: U Patient ID: NG		Specimen: EN304714K Collected: 08/10/2017 Received: 08/10/2017 / 22:53 PDT Reported: 08/11/2017 / 10:50 PDT	Client #: 76020042 JALIL, MARIAN

Test Name	In Range	Out Of Range	Reference Range	Lab
RED BLOOD CELL COUNT	4.53		4.20-5.10 Million/uL	
HEMOGLOBIN		13.1 L	13.2-15.5 g/dL	
HEMATOCRIT		37.7 L	38.5-45.0 %	
MCV	83.2		80.0-100.0 fL	
MCH	28.9		27.0-33.0 pg	
MCHC	34.7		32.0-36.0 g/dL	
RDW	12.4		11.0-15.0 %	
PLATELET COUNT	342		140-400 Thousand/uL	
MPV	10.7		7.5-12.5 fL	
ABSOLUTE NEUTROPHILS	5127		1500-7800 cells/uL	
ABSOLUTE LYMPHOCYTES	2349		850-3900 cells/uL	
ABSOLUTE MONOCYTES	462		200-950 cells/uL	
ABSOLUTE EOSINOPHILS	130		15-500 cells/uL	
ABSOLUTE BASOPHILS	32		0-200 cells/uL	
ABSOLUTE NUCLEATED RBC	0		0 cells/uL	
NEUTROPHILS	63.3		%	
LYMPHOCYTES	29.0		%	
MONOCYTES	5.7		%	
EOSINOPHILS	1.6		%	
BASOPHILS	0.4		%	

PERFORMING SITE:

EN QUEST DIAGNOSTICS-WEST HILLS, 8401 FALLBROOK AVENUE E, WEST HILLS, CA 91304-3226 Laboratory Director: TAB TOOCHINDA, MD, CLIA: 05I00642K27



Patient Information		Specimen Information	Client Information	
DELAHOUSSAYE, REINA DOB: 12/29/1986 AGE: 28 Gender: F Patient ID: 19861229FRD Health ID: 8573013469939477		Specimen: EN794885Q Collected: 03/23/2015 / 08:35 PDT Received: 03/24/2015 / 14:13 PDT Reported: 03/26/2015 / 02:50 PDT	Client #: 76020042 JALIL, MARIAN	

Test Name	In Range	Out Of Range	Reference Range	Lab
NON HDL CHOLESTEROL		239 H	mg/dL (calc)	EN
		Target for non-HDL cholesterol is 30 mg/dL higher than LDL cholesterol target.		
COMPREHENSIVE METABOLIC PANEL GLUCOSE		324 H	65-99 mg/dL	EN

UREA NITROGEN (BUN)	10	7-25 mg/dL
CREATININE	0.64	0.50-1.10 mg/dL
eGFR NON-AFR. AMERICAN	121	> OR = 60 mL/min/1.73m ²
eGFR AFRICAN AMERICAN	141	> OR = 60 mL/min/1.73m ²
BUN/CREATININE RATIO	NOT APPLICABLE	6-22 (calc)
SODIUM	134 L	135-146 mmol/L
POTASSIUM	4.3	3.5-5.3 mmol/L
CHLORIDE	100	98-110 mmol/L
CARBON DIOXIDE	24	19-30 mmol/L
CALCIUM	9.0	8.6-10.2 mg/dL
PROTEIN, TOTAL	6.7	6.1-8.1 g/dL
ALBUMIN	4.0	3.6-5.1 g/dL
GLOBULIN	2.7	1.9-3.7 g/dL (calc)
ALBUMIN/GLOBULIN RATIO	1.5	1.0-2.5 (calc)
BILIRUBIN, TOTAL	0.5	0.2-1.2 mg/dL
ALKALINE PHOSPHATASE	77	33-115 U/L
AST	31 H	10-30 U/L
ALT	43 H	6-29 U/L

HEMOGLOBIN A1C WITH MPG

HEMOGLOBIN A1c 12.6 H <5.7 % of total Hgb

According to ADA guidelines, hemoglobin A1c <7.0% represents optimal control in non-pregnant diabetic patients. Different metrics may apply to specific patient populations. Standards of Medical Care in Diabetes-2013. Diabetes Care. 2013;36:s11-s66

For the purpose of screening for the presence of diabetes

- <5.7% Consistent with the absence of diabetes
- 5.7-6.4% Consistent with increased risk for diabetes (prediabetes)
- >or=6.5% Consistent with diabetes

This assay result is consistent with diabetes mellitus.

Currently, no consensus exists for use of hemoglobin A1c for diagnosis of diabetes for children.

MEAN PLASMA GLUCOSE	371	mg/dL (calc)
HEPATIC FUNCTION PANEL		EN
PROTEIN, TOTAL	6.7	6.1-8.1 g/dL
ALBUMIN	4.0	3.6-5.1 g/dL
GLOBULIN	2.7	1.9-3.7 g/dL (calc)
ALBUMIN/GLOBULIN RATIO	1.5	1.0-2.5 (calc)
BILIRUBIN, TOTAL	0.5	0.2-1.2 mg/dL
BILIRUBIN, DIRECT	0.1	< OR = 0.2 mg/dL
BILIRUBIN, INDIRECT	0.4	0.2-1.2 mg/dL (calc)



Report Status: Final

DELAHOUSSAYE, REINA

Patient Information		Specimen Information		Client Information	
DELAHOUSSAYE, REINA		Specimen: EN794885Q		Client #: 76020042	
DOB: 12/29/1986	AGE: 28	Collected: 03/23/2015 / 08:35 PDT		JALIL, MARIAN	
Gender: F		Received: 03/24/2015 / 14:13 PDT			
Patient ID: 19861229FRD		Reported: 03/26/2015 / 02:50 PDT			
Health ID: 8573013469939477					
Test Name		In Range	Out Of Range	Reference Range	Lab
ALKALINE PHOSPHATASE		77		33-115 U/L	
AST			31 H	10-30 U/L	
ALT			43 H	6-29 U/L	
CBC (H/H, RBC, INDICES, WBC, PLT)					EN
WHITE BLOOD CELL COUNT	5.3			3.8-10.8 Thousand/uL	
RED BLOOD CELL COUNT	4.81			3.80-5.10 Million/uL	
HEMOGLOBIN	13.7			11.7-15.5 g/dL	
HEMATOCRIT	40.5			35.0-45.0 %	
MCV	84.2			80.0-100.0 fL	
MCH	28.4			27.0-33.0 pg	
MCHC	33.8			32.0-36.0 g/dL	
RDW	12.7			11.0-15.0 %	
PLATELET COUNT	250			140-400 Thousand/uL	
URINALYSIS, COMPLETE W/REFLEX TO CULTURE					EN
COLOR	YELLOW			YELLOW	
APPEARANCE	CLEAR			CLEAR	
SPECIFIC GRAVITY		1.044 H		1.001-1.035	
PH	6.0			5.0-8.0	
GLUCOSE		3+		NEGATIVE	
BILIRUBIN	NEGATIVE			NEGATIVE	
KETONES	NEGATIVE			NEGATIVE	
OCCULT BLOOD	NEGATIVE			NEGATIVE	
PROTEIN	NEGATIVE			NEGATIVE	
NITRITE	NEGATIVE			NEGATIVE	
LEUKOCYTE ESTERASE	NEGATIVE			NEGATIVE	
WBC	0-5			< OR = 5 /HPF	
RBC	0-2			< OR = 2 /HPF	
SQUAMOUS EPITHELIAL CELLS	0-5			< OR = 5 /HPF	
BACTERIA		FEW		NONE SEEN /HPF	
HYALINE CAST	NONE SEEN			NONE SEEN /LPF	
REFLEXIVE URINE CULTURE		NO CULTURE INDICATED			EN

Endnote 1 Reference Range
Not established



Report Status: Final
DELAHOUSSAYE, REINA

Patient Information	Specimen Information	Client Information
DELAHOUSSAYE, REINA DOB: 12/29/1986 AGE: 28 Gender: F Patient ID: 19861229FRD Health ID: 8573013469939477	Specimen: EN794885Q Collected: 03/23/2015 / 08:35 PDT Received: 03/24/2015 / 14:13 PDT Reported: 03/26/2015 / 02:50 PDT	Client #: 76020042 JALIL, MARIAN

QUESTASSURED 25-OH VIT D, (D2,D3), LC/MS/MS

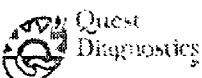
QUESTASSURED 25-OH VIT D, (D2,D3), LC/MS/MS

Lab: SLI

Test Name	Results	Reference Range
VITAMIN D, 25-OH, TOTAL	20 L	30-100 ng/mL
25-OHD3 indicates both endogenous production and supplementation. 25-OHD2 is an indicator of exogenous sources, such as diet or supplementation. Therapy is based on measurement of Total 25-OHD, with levels <20 ng/mL indicative of Vitamin D deficiency, while levels between 20 ng/mL and 30 ng/mL suggest insufficiency. Optimal levels are > or = 30 ng/mL.		
VITAMIN D, 25-OH, D3	10	See Below ng/mL
Reference Range: Not established		
VITAMIN D, 25-OH, D2	10	See Below ng/mL
Reference Range: Not established		

PERFORMING SITE:

EN QUEST DIAGNOSTICS-WEST HILLS, 8401 FALLBROOK AVENUE, WEST HILLS, CA 91304-3226 Laboratory Director: GEOFREY H. MOYER,MD,PHD, CLIA: 05D0042827
 SLI QUEST DIAGNOSTICS NICHOLS VALENCIA, 27027 TOURNEY ROAD, VALENCIA, CA 91355-5386 Laboratory Director: BASEL KASHLAN,MD,FCAP, CLIA: 05D0550302



Report Status: Final
DELAHOUSSAYE, REINA

Patient Information	Specimen Information	Client Information
DELAHOUSSAYE, REINA DOB: 12/29/1986 AGE: 28 Gender: F Phone: 562.842.5856 Patient ID: 19861229FRD Health ID: 8573013469939477	Specimen: EN794885Q Requisition: 0003319 Collected: 03/23/2015 / 08:35 PDT Received: 03/24/2015 / 14:13 PDT Reported: 03/26/2015 / 02:50 PDT	Client #: 76020042 MAIL0000 JALIL, MARIAN MARIAN JALIL, M.D. 14350 WHITTIER BLVD STE 200 WHITTIER, CA 90605-2148

COMMENTS: FASTING: YES

Test Name	In Range	Out Of Range	Reference Range	Lab
MICROALBUMIN, RANDOM URINE (W/CREATININE)				
CREATININE, RANDOM URINE	75		20-320 mg/dL	EN
MICROALBUMIN, RANDOM URINE (W/CREATININE)				EN
MICROALBUMIN	0.3		mg/dL	

See Endnote 1

MICROALBUMIN/CREATININE RATIO, RANDOM URINE	4	<30 mcg/mg creat
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The ADA defines abnormalities in albumin excretion as follows:

Category Result (mcg/mg creatinine)

Normal	<30
Microalbuminuria	30-299
Clinical albuminuria	> OR = 300

The ADA recommends that at least two of three specimens collected within a 3-6 month period be abnormal before considering a patient to be within a diagnostic category.

THYROID PANEL WITH TSH

THYROID PANEL				EN
T3 UPTAKE	30		22-35 %	
T4 (THYROXINE), TOTAL	7.6		4.5-12.0 mcg/dL	
FREE T4 INDEX (T7)	2.3		1.4-3.8	
TSH	2.77		mIU/L	EN

Reference Range

> or = 20 Years 0.40-4.50

Pregnancy Ranges

First trimester	0.26-2.66
Second trimester	0.55-2.73
Third trimester	0.43-2.91

LIPID PANEL

CHOLESTEROL, TOTAL	270 H	125-200 mg/dL	EN
HDL CHOLESTEROL	31 L	> OR = 46 mg/dL	EN
TRIGLYCERIDES	763 H	<150 mg/dL	EN
LDL-CHOLESTEROL		<130 mg/dL (calc)	EN

LDL cholesterol not calculated. Triglyceride levels greater than 400 mg/dL invalidate calculated LDL results.

Desirable range <100 mg/dL for patients with CHD or diabetes and <70 mg/dL for diabetic patients with known heart disease.

CHOL/HDLC RATIO	8.7 H	< OR = 5.0 (calc)	EN
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Patient Information	Specimen Information	Client Information
DELAHOUSSAYE, REINA DOB: 12/29/1986 AGE: 28 Gender: F Phone: 562.842.5856 Patient ID: 19861229FRD Health ID: 8573013469939477	Specimen: EN794885Q Requisition: 0003319 Collected: 03/23/2015 / 08:35 PDT Received: 03/24/2015 / 14:13 PDT Faxed: 03/31/2015 / 11:28 PDT	Client #: 76020042 MAIL0000 JALIL, MARIAN MARIAN JALIL, M.D. 14350 WHITTIER BLVD STE 200 WHITTIER, CA 90605-2148

COMMENTS: FASTING: YES

Test Name	In Range	Out Of Range	Reference Range	Lab
MICROALBUMIN, RANDOM URINE (W/CREATININE)				
CREATININE, RANDOM URINE	75		20-320 mg/dL	EN
MICROALBUMIN, RANDOM URINE (W/CREATININE)				EN
MICROALBUMIN	0.3		mg/dL	
<i>See Endnote 1</i>				
MICROALBUMIN/CREATININE RATIO, RANDOM URINE	4		<30 mcg/mg creat	

The ADA defines abnormalities in albumin excretion as follows:

Category Result (mcg/mg creatinine)

Normal	<30
Microalbuminuria	30-299
Clinical albuminuria	> OR = 300

The ADA recommends that at least two or three specimens collected within a 3-6 month period be abnormal before considering a patient to be within a diagnostic category.

THYROID PANEL WITH TSH

THYROID PANEL

T3 UPTAKE	3.0	22-35 %	EN
T4 (THYROXINE), TOTAL	7.6	4.5-12.0 mcg/dL	
FREE T4 INDEX (T7)	2.3	1.4-3.8	
TSH	2.77	miU/L	EN

Reference Range

> or = 20 Years 0.40-4.50

Pregnancy Ranges

First trimester	0.26-2.66
Second trimester	0.55-2.73
Third trimester	0.43-2.91

LIPID PANEL

CHOLESTEROL, TOTAL	270 H	125-200 mg/dL	EN
HDL CHOLESTEROL	31 L	> OR = 46 mg/dL	EN
TRIGLYCERIDES	763 H	<150 mg/dL	EN
LDL-CHOLESTEROL	*	<130 mg/dL (calc)	EN

LDL cholesterol not calculated. Triglyceride levels greater than 400 mg/dL invalidate calculated LDL results.

Desirable range <100 mg/dL for patients with CHD or diabetes and <70 mg/dL for diabetic patients with known heart disease.

CHOL/HDL C RATIO

8.7 H < OR = 5.0 (calc)

EN

Patient Information	Specimen Information	Client Information
DELAHOUSSAYE, REINA DOB: 12/29/1986 AGE: 28 Gender: F Patient ID: 19861229FRD Health ID: 8573013469939477	Specimen: EN794885Q Collected: 03/23/2015 / 08:35 PDT Received: 03/24/2015 / 14:13 PDT Faxed: 03/31/2015 / 11:28 PDT	Client #: 76020042 JALIL, MARIAN

Test Name	In Range	Out Of Range	Reference Range	Lab
NON HDL CHOLESTEROL		239 H	mg/dL (calc)	EN
		Target For non-HDL cholesterol is 30 mg/dL higher than LDL cholesterol target.		
COMPREHENSIVE METABOLIC PANEL				EN

GLUCOSE 324 H 65-99 mg/dL

Fasting reference interval

UREA NITROGEN (BUN)	10	7-25 mg/dL
CREATININE	0.64	0.50-1.10 mg/dL
eGFR NON-AFR. AMERICAN	121	> OR = 60 mL/min/1.73m ²
eGFR AFRICAN AMERICAN	141	> OR = 60 mL/min/1.73m ²
BUN/CREATININE RATIO	NOT APPLICABLE	6-22 (calc)
SODIUM	134 L	135-146 mmol/L
POTASSIUM	4.3	3.5-5.3 mmol/L
CHLORIDE	100	98-110 mmol/L
CARBON DIOXIDE	24	19-30 mmol/L
CALCIUM	9.0	8.6-10.2 mg/dL
PROTEIN, TOTAL	6.7	6.1-8.1 g/dL
ALBUMIN	4.0	3.6-5.1 g/dL
GLOBULIN	2.7	1.9-3.7 g/dL (calc)
ALBUMIN/GLOBULIN RATIO	1.5	1.0-2.5 (calc)
BILIRUBIN, TOTAL	0.5	0.2-1.2 mg/dL
ALKALINE PHOSPHATASE	77	33-115 U/L
AST	31 H	10-30 U/L
ALT	43 H	5-29 U/L

HEMOGLOBIN A1C WITH MPG

HEMOGLOBIN A1c

According to ADA guidelines, hemoglobin A1c <7.0% represents optimal control in non-pregnant diabetic patients. Different metrics may apply to specific patient populations. Standards of Medical Care in Diabetes-2013. Diabetes Care. 2013;36:s11-s66

≤5.7 % of total Hgb

EN

For the purpose of screening for the presence of diabetes

- <5.7% Consistent with the absence of diabetes
- 5.7-6.4% Consistent with increased risk for diabetes (prediabetes)
- >or=6.5% Consistent with diabetes

This assay result is consistent with diabetes mellitus.

Currently, no consensus exists for use of hemoglobin A1c for diagnosis of diabetes for children.

MEAN PLASMA GLUCOSE	371	mg/dL (calc)
HEPATIC FUNCTION PANEL		
PROTEIN, TOTAL	6.7	6.1-8.1 g/dL
ALBUMIN	4.0	3.6-5.1 g/dL
GLOBULIN	2.7	1.9-3.7 g/dL (calc)
ALBUMIN/GLOBULIN RATIO	1.5	1.0-2.5 (calc)
BILIRUBIN, TOTAL	0.5	0.2-1.2 mg/dL
BILIRUBIN, DIRECT	0.1	< OR = 0.2 mg/dL
BILIRUBIN, INDIRECT	0.4	0.2-1.2 mg/dL (calc)



Patient Information	Specimen Information	Client Information
DELAHOUSSAYE, REINA DOB: 12/29/1986 AGE: 28 Gender: F Patient ID: 19861229FRD Health ID: 8573013469939477	Specimen: EN794885Q Collected: 03/23/2015 / 08:35 PDT Received: 03/24/2015 / 14:13 PDT Faxed: 03/31/2015 / 11:28 PDT	Client #: 76020042 JALIL, MARIAN

Test Name	In Range	Out Of Range	Reference Range	Lab
ALKALINE PHOSPHATASE	77		33-115 U/L	
AST		31 H	10-30 U/L	
ALT		43 H	6-29 U/L	
CBC (H/H, RBC, INDICES, WBC, PLT)				EN
WHITE BLOOD CELL COUNT	5.3		3.8-10.8 Thousand/uL	
RED BLOOD CELL COUNT	4.81		3.80-5.10 Million/uL	
HEMOGLOBIN	13.7		11.7-15.5 g/dL	
HEMATOCRIT	40.5		35.0-45.0 %	
MCV	84.2		80.0-100.0 fL	
MCH	28.4		27.0-33.0 pg	
MCHC	33.8		32.0-36.0 g/dL	
RDW	12.7		11.0-15.0 %	
PLATELET COUNT	250		140-400 Thousand/uL	
URINALYSIS, COMPLETE W/REFLEX TO CULTURE				EN
COLOR	YELLOW		YELLOW	
APPEARANCE	CLEAR		CLEAR	
SPECIFIC GRAVITY		1.044 H	1.001-1.035	
pH	6.0		5.0-8.0	
GLUCOSE		3+	NEGATIVE	
BILIRUBIN	NEGATIVE		NEGATIVE	
KETONES	NEGATIVE		NEGATIVE	
OCCULT BLOOD	NEGATIVE		NEGATIVE	
PROTEIN	NEGATIVE		NEGATIVE	
NITRITE	NEGATIVE		NEGATIVE	
LEUKOCYTE ESTERASE	NEGATIVE		NEGATIVE	
WBC	0-5		< OR = 5 /HPF	
RBC	0-2		< OR = 2 /HPF	
SQUAMOUS EPITHELIAL CELLS	0-5		< OR = 5 /HPF	
BACTERIA		FEW	NONE SEEN /HPF	
HYALINE CAST	NONE SEEN		NONE SEEN /LPF	
REFLEXIVE URINE CULTURE		NO CULTURE INDICATED		EN

Endnote 1 Reference Range
Not established



Patient Information	Specimen Information	Client Information
DELAHOUSSAYE, REINA DOB: 12/29/1986 AGE: 28 Gender: F Patient ID: 19861229FRD Health ID: 8573013469939477	Specimen: EN794885Q Collected: 03/23/2015 / 08:35 PDT Received: 03/24/2015 / 14:13 PDT Faxed: 03/31/2015 / 11:28 PDT	Client #: 76020042 JALIL, MARIAN

QUESTASSURED 25-OH VIT D, (D2,D3), LC/MS/MS

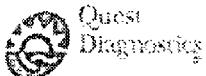
QUESTASSURED 25-OH VIT D, (D2,D3), LC/MS/MS

Lab: SLI

Test Name	Results	Reference Range
VITAMIN D, 25-OH, TOTAL	20 L	50-100 ng/mL
25-OHD3 indicates both endogenous production and supplementation. 25-OHD2 is an indicator of exogenous sources, such as diet or supplementation. Therapy is based on measurement of Total 25-OHD, with levels <20 ng/mL, indicative of Vitamin D deficiency, while levels between 20 ng/mL and 30 ng/mL suggest insufficiency. Optimal levels are + or - 30 ng/mL.		
VITAMIN D, 25-OH, D3	10	See Below ng/mL
Reference Range: Not established		
VITAMIN D, 25-OH, D2	10	See Below ng/mL
Reference Range: Not established		

PERFORMING SITE:

EN - QUEST DIAGNOSTICS-WEST HILLS, 8401 FULLEROCK AVENUE, WEST HILLS, CA 91344-2226 Laboratory Director: GENE FERRY, MD, PhD, CLIA: 05D061D27
 SLI - QUEST DIAGNOSIS-SIUSPAC, 351 BNY TA 25027, FOURNEY ROAD, VALERICA, NY 10595-5586 Laboratory Director: BASIL KASPLAK, MD, FAAP, CLIA: 05D055051



Patient Information		Specimen Information	Client Information
DELAHOUSAYE, REINA DOB: 12/29/1986 AGE: 27 Gender: F Fasting: U Phone: NG Patient ID: NG		Specimen: EN722618V Requisition: 2899092 Collected: 01/22/2014 Received: 01/23/2014 / 01:43 PST Reported: 01/28/2014 / 13:26 PST	Client #: 76020042 MAIL0000 JALIL, MARIAN MARIAN JALIL, M.D. 14350 WHITTIER BLVD STE 200 WHITTIER, CA 90605-2148

Test Name	In Range	Out Of Range	Reference Range	Lab
CHLAMYDIA/N. GONORRHOEAE DNA, SDA				AMD
CHLAMYDIA TRACHOMATIS DNA, SDA	Not Detected	✓	Not Detected	
NEISSERIA GONORRHOEAE DNA, SDA	Not Detected	✓	Not Detected	

This test was performed using the BD ProbeTEC™ Chlamydia trachomatis and Neisseria gonorrhoeae Amplified DNA Assays.

The performance characteristics of this assay have been determined by Quest Diagnostics Nichols Institute. Performance characteristics refer to the analytical performance of the test.

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EN

CULTURE, GENITAL

MICRO NUMBER: 40105640
 TEST STATUS: FINAL
 SPECIMEN SOURCE: VAGINA
 SPECIMEN QUALITY: ADEQUATE
 RESULT: Heavy growth of
 Yeast isolated. Please contact the laboratory
 within 3 days if further identification is
 desired.
 Normal urogenital flora also present.

PERFORMING SITE:

AMD QUEST DIAGNOSTICS/NICHOOLS CHANTILLY, 14225 NEWBROOK DRIVE, CHANTILLY, VA 20151-2228 Laboratory Director: KENNETH L. SISCO, MD, CLIA: 49D0221801
 EN QUEST DIAGNOSTICS-WEST HILLS, 8401 FALLBROOK AVENUE, WEST HILLS, CA 91304-3226 Laboratory Director: GORDON L. LOVE, MD, CLIA: 05D0642827

*Delivery 1/28/14
 T 1/28/14
 Given this
 on 1/28/14*



Report Status: Final
DE LA HOUSAYE, REINA

Patient Information	Specimen Information	Client Information
DE LA HOUSAYE, REINA DOB: 12/29/1986 AGE: 27 Gender: F Phone: 562.395.8053 Patient ID: 12291986RD Health ID: 8573006149016302	Specimen: EN748902V Requisition: 0002577 Collected: 01/23/2014 / 11:08 PST Received: 01/24/2014 / 00:45 PST Reported: 01/25/2014 / 15:55 PST	Client #: 76020042 MAIL0000 JALIL, MARIAN MARIAN JALIL, M.D. 14350 WHITTIER BLVD STE 200 WHITTIER, CA 90605-2148

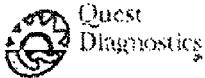
COMMENTS: FASTING
AN UPDATE OR CORRECTION HAS BEEN MADE TO NAME

Test Name	In Range	Out Of Range	Reference Range	Lab
THYROID PANEL WITH TSH				
THYROID PANEL				
T3 UPTAKE	26		22-35 %	
T4 (THYROXINE), TOTAL	8.4		4.5-12.0 mcg/dL	
FREE T4 INDEX (T7)	2.2		1.4-3.8	
TSH	2.23		mIU/L	
			Reference Range	
			> or = 20 Years 0.40-4.50	
			Pregnancy Ranges	
			First trimester 0.26-2.66	
			Second trimester 0.55-2.73	
			Third trimester 0.43-2.91	
COMPREHENSIVE METABOLIC PANEL				EN
GLUCOSE		288 H	65-99 mg/dL	
			Fasting reference interval	
UREA NITROGEN (BUN)	9		7-25 mg/dL	
CREATININE	0.63		0.50-1.10 mg/dL	
eGFR NON-AFR. AMERICAN	123		> OR = 60 mL/min/1.73m ²	
eGFR AFRICAN AMERICAN	142		> OR = 60 mL/min/1.73m ²	
BUN/CREATININE RATIO	NOT APPLICABLE		6-22 (calc)	
SODIUM	136		135-146 mmol/L	
POTASSIUM	4.2		3.5-5.3 mmol/L	
CHLORIDE	102		98-110 mmol/L	
CARBON DIOXIDE	24		19-30 mmol/L	
CALCIUM	9.3		8.6-10.2 mg/dL	
PROTEIN, TOTAL	7.1		6.1-8.1 g/dL	
ALBUMIN	4.3		3.6-5.1 g/dL	
GLOBULIN	2.8		1.9-3.7 g/dL (calc)	
ALBUMIN/GLOBULIN RATIO	1.5		1.0-2.5 (calc)	
BILIRUBIN, TOTAL	0.5		0.2-1.2 mg/dL	
ALKALINE PHOSPHATASE	74		33-115 U/L	
AST	16		10-30 U/L	
ALT	21		6-29 U/L	
HEMOGLOBIN A1C WITH MPG				
HEMOGLOBIN A1c		11.9 H	<5.7 % of total Hgb	EN

According to ADA guidelines, hemoglobin A1c <7.0% represents optimal control in non-pregnant diabetic patients. Different metrics may apply to specific patient populations. Standards of Medical Care in Diabetes-2013. Diabetes Care. 2013;36:s11-s66

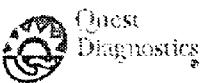
For the purpose of screening for the presence of diabetes

- <5.7% Consistent with the absence of diabetes
- 5.7-6.4% Consistent with increased risk for diabetes (prediabetes)



Patient Information		Specimen Information		Client Information	
DE LA HOUSAYE, REINA		Specimen: EN748902V		Client #: 76020042	
DOB: 12/29/1986	AGE: 27	Collected: 01/23/2014 / 11:08 PST		JALIL, MARIAN	
Gender: F		Received: 01/24/2014 / 00:45 PST			
Patient ID: 12291986RD		Reported: 01/25/2014 / 15:55 PST			
Health ID: 8573006149016302					

Test Name	In Range	Out Of Range	Reference Range	Lab
>or=6.5% Consistent with diabetes				
This assay result is consistent with diabetes mellitus.				
Currently, no consensus exists for use of hemoglobin A1c for diagnosis of diabetes for children.				
MEAN PLASMA GLUCOSE	346		mg/dL (calc)	
HEPATIC FUNCTION PANEL				EN
PROTEIN, TOTAL	7.1		6.1-8.1 g/dL	
ALBUMIN	4.3		3.6-5.1 g/dL	
GLOBULIN	2.8		1.9-3.7 g/dL (calc)	
ALBUMIN/GLOBULIN RATIO	1.5		1.0-2.5 (calc)	
BILIRUBIN, TOTAL	0.5		0.2-1.2 mg/dL	
BILIRUBIN, DIRECT	0.1		< OR = 0.2 mg/dL	
BILIRUBIN, INDIRECT	0.4		0.2-1.2 mg/dL (calc)	
ALKALINE PHOSPHATASE	74		33-115 U/L	
AST	16		10-30 U/L	
ALT	21		6-29 U/L	
URINALYSIS, COMPLETE W/REFLEX TO CULTURE				EN
COLOR	YELLOW		YELLOW	
APPEARANCE	CLEAR		CLEAR	
SPECIFIC GRAVITY	1.033		1.001-1.035	
PH	6.0		5.0-8.0	
GLUCOSE		3+	NEGATIVE	
BILIRUBIN	NEGATIVE		NEGATIVE	
KETONES	NEGATIVE		NEGATIVE	
OCCULT BLOOD	NEGATIVE		NEGATIVE	
PROTEIN	NEGATIVE		NEGATIVE	
NITRITE	NEGATIVE		NEGATIVE	
LEUKOCYTE ESTERASE	NEGATIVE		NEGATIVE	
WBC	0-5		< OR = 5 /HPF	
RBC	0-3		< OR = 3 /HPF	
SQUAMOUS EPITHELIAL CELLS		10-20	< OR = 5 /HPF	
BACTERIA		FEW	NONE SEEN /HPF	
HYALINE CAST	NONE SEEN		NONE SEEN /LPF	
CBC (INCLUDES DIFF/PLT)				EN
WHITE BLOOD CELL COUNT	6.3		3.8-10.8 Thousand/uL	
RED BLOOD CELL COUNT	5.06		3.80-5.10 Million/uL	
HEMOGLOBIN	14.3		11.7-15.5 g/dL	
HEMATOCRIT	41.8		35.0-45.0 %	
MCV	82.5		80.0-100.0 fL	
MCH	28.3		27.0-33.0 pg	
MCHC	34.3		32.0-36.0 g/dL	
RDW	12.3		11.0-15.0 %	
PLATELET COUNT	298		140-400 Thousand/uL	
MPV	8.8		7.5-11.5 fL	
ABSOLUTE NEUTROPHILS	3326		1500-7800 cells/uL	
ABSOLUTE LYMPHOCYTES	2230		850-3900 cells/uL	
ABSOLUTE MONOCYTES	460		200-950 cells/uL	
ABSOLUTE EOSINOPHILS	246		15-500 cells/uL	
ABSOLUTE BASOPHILS	38		0-200 cells/uL	
NEUTROPHILS	52.8		%	
LYMPHOCYTES	35.4		%	
MONOCYTES	7.3		%	



Report Status: Final
DE LA HOUSAYE, REINA

Patient Information	Specimen Information	Client Information
DE LA HOUSAYE, REINA DOB: 12/29/1986 AGE: 27 Gender: F Patient ID: 12291986RD Health ID: 8573006149016302	Specimen: EN748902V Collected: 01/23/2014 / 11:08 PST Received: 01/24/2014 / 00:45 PST Reported: 01/25/2014 / 15:55 PST	Client #: 76020042 JALIL, MARIAN

Test Name	In Range	Out Of Range	Reference Range	Lab
EOSINOPHILS	3.9	%	%	
BASOPHILS	0.6	%	%	
REFLEXIVE URINE CULTURE	NO CULTURE INDICATED			EN



Report Status: Final
DE LA HOUSAYE, REINA

Patient Information	Specimen Information	Client Information
DE LA HOUSAYE, REINA DOB: 12/29/1986 AGE: 27 Gender: F Patient ID: 12291986RD Health ID: 8573006149016302	Specimen: EN748902V Collected: 01/23/2014 / 11:08 PST Received: 01/24/2014 / 00:45 PST Reported: 01/25/2014 / 15:55 PST	Client #: 76020042 JALIL, MARIAN

QUESTASSURED 25-OH VIT D, (D2,D3), LC/MS/MS

QUESTASSURED 25-OH VIT D, (D2,D3), LC/MS/MS

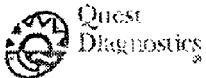
Lab: SLI

Test Name	Results	Reference Range
VITAMIN D, 25-OH, TOTAL	10.1	30-100 ng/mL
25-OHD3 indicates both endogenous production and supplementation. 25-OHD2 is an indicator of exogenous sources, such as diet or supplementation. Therapy is based on measurement of Total 25-OHD, with levels <20 ng/mL indicative of Vitamin D deficiency, while levels between 20 ng/mL and 30 ng/mL suggest insufficiency. Optimal levels are > or = 30 ng/mL.		
VITAMIN D, 25-OH, D3	10	See Below ng/mL
Reference Range: Not established		
VITAMIN D, 25-OH, D2	<4	See Below ng/mL
Reference Range: Not established		

PERFORMING SITE:

EN QUEST DIAGNOSTICS-WEST HILLS, 8401 FALLBROOK AVENUE, WEST HILLS, CA 91304-3226 Laboratory Director: GORDON L. LOVE, MD, CLIA: 05D0642827
 SLI QUEST DIAGNOSTICS NICHOLS VALENCIA, 27027 TOURNEY ROAD, VALENCIA, CA 91355-5386 Laboratory Director: MICHAEL C DUGAN, MD, FCAP, CLIA: 05D0550302

OK Done
 Vitam D 5000iu T QD #30
 X 3 mfu



Report Status: Final
DELAHOUSEY, REINA

Patient Information	Specimen Information	Client Information
DELAHOUSEY, REINA DOB: 12/29/1986 AGE: 27 Gender: F Fasting: U Phone: NG Patient ID: NG	Specimen: EN729016V Requisition: 9548794 Collected: 01/22/2014 Received: 01/23/2014 / 03:11 PST Reported: 01/23/2014 / 14:39 PST	Client #: 76020042 MAIL0000 JALIL, MARIAN MARIAN JALIL, M.D. 14350 WHITTIER BLVD STE 200 WHITTIER, CA 90605-2148

SUREPATH PAP RFX HR HPV		Lab: JN
STATEMENT OF ADEQUACY: Satisfactory for evaluation. Endocervical/transformation zone component present. SOURCE: Vagina, Cervix, Endocervix CLINICAL INFORMATION: NONE GIVEN LMP: 1/4/14 prev. Pap: NONE GIVEN prev. Bx: NONE GIVEN	CATEGORY AND INTERPRETATION: Negative for intraepithelial lesion or malignancy. Fungal organisms morphologically consistent with Candida spp.	<input checked="" type="checkbox"/> ✓ <i>already done this 1/21/14 in case</i> <i>Difuse + now expect ~70°</i> <i>#2</i>

PERFORMING SITE:

IN QUEST DIAGNOSTICS, 8403 FALLBROOK AVENUE, WEST HILLS, CA 91304-3226 Laboratory Director: GORDON L. LOVE, MD, CLIA: 05D0939429

LABORATORY REPORT

MARIAN JALIL, M.D. 20042
 14350 E. WHITTIER BL. #200 1001
 WHITTIER, CA 90605 1005



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 TARZANA, CA 91356
 (818) 996-7300
 (800) 339-4299

DOB: 12/29/1986

PATIENT NAME REINO, DELAHOUSSY			PATIENT ID	ROOM NO.	AGE 19	SEX F	PHYSICIAN
PAGE	REQUISITION NO.	ACCESSION NO.	LAB REF. #	COLLECTION DATE & TIME	LOG-IN DATE	REPORT DATE	& TIME
		92519362		04/18/2006 NG	04/19/06	04/19/06	12:36PM

REMARKS

FASTING: NO

KENNETH L. SISCO, M.D., Ph.D. MEDICAL DIRECTOR, CLINICAL PATHOLOGY
 PAUL T. WERTLAKE, M.D. MEDICAL DIRECTOR, ANATOMIC PATHOLOGY

REPORT STATUS	FINAL	TEST	RESULT	UNITS	REFERENCE RANGE	SITE CODE
			IN RANGE	OUT OF RANGE		

HEMOGLOBIN A1C (INTEGRA)

HEMOGLOBIN A1C

MEAN PLASMA GLUCOSE

321

11.2 H (1)%

MG/DL

SEE FOOTNOTE

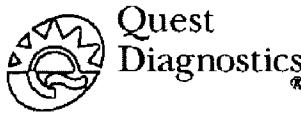
Footnotes:

(1)	Hb A1c (%)	Glucose Control Index
	>8	Additional Action Suggestion
	<7	Goal
	<6	Non-Diabetic

Factors such as duration of diabetes, adherence to therapy, and patient age should be considered in assessing blood glucose control. Suggested values are for non-pregnant individuals. "Additional action suggested" depends on individual patient circumstances and should be interpreted in conjunction with complete patient presentation.

FIRST FINAL REPORT DATE: 04/19/2006 AT 12:36PM
 PAGE 1 :END OF FINAL REPORT FOR: DELAHOUSSY REINO
 DATE COLLECTED: 04/18/2006 REPORTED DATE: 04/19/2006

INDICATES TESTING SITE SEE REVERSE SIDE



AT	Quest Diagnostics 1777 Montreal Circle Tucker, GA 30084 (770) 934-9205 Medical Director: W.M. Miller, M.D. Laboratory Director: Pat Ben-Day	KY	Quest Diagnostics 2277 Charleston Drive Lexington, KY 40505 (606) 299-3866 Medical Director: J. E. Dunnington, M.D.	OSD	Quest Diagnostics 7470 Mission Valley Road San Diego, CA 92108 (619) 686-3000 Medical Director: Daniel Molden, M.D.
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DF	Quest Diagnostics 38700 Country Club Drive Farmington Hills, MI 48331 (313) 468-2300 Laboratory Director: K. Shah, M.D.	NO	Quest Diagnostics 4648 10 Service Road West Metairie, LA 70001 (504) 889-2307 Medical Director: Carol Sartin, M.D.	TP	Quest Diagnostics 4225 E. Fowler Avenue Tempe, AZ 85117 (602) 972-7100 Medical Director: Harvey Kincaid, Ph.D.
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				SM	Quest Diagnostics 101 S. San Mateo, # 107 San Mateo, CA 94401 (650) 348-5221 Laboratory Director: Paul Ortega, M.D.		

LABORATORY REPORT

MARIAN JALIL, M.D. 20042
 14350 E. WHITTIER BLVD. #200 1001
 WHITTIER, CA 90605 1005

PATIENT PHONE: (562) 777-7414
 DOB: 12/29/1986



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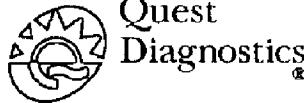
PATIENT NAME	PATIENT ID	ROOM NO.	AGE	SEX	PHYSICIAN		
DELAHOUSSAYE, REINA A	603-28-5885		19	NG	MARIAN JALIL, M.D.		
PAGE	REQUISITION NO.	ACCESSION NO.	LAB REP. #	COLLECTION DATE & TIME	LOG-IN DATE	REPORT DATE	& TIME
	302121562			04/10/2006 NG	04/11/06	04/15/06	2:21AM

REMARKS
 FASTING: NO
 KENNETH L. SISCO, M.D., Ph.D. MEDICAL DIRECTOR, CLINICAL PATHOLOGY
 PAUL T. WERTLAKE, M.D. MEDICAL DIRECTOR, ANATOMIC PATHOLOGY

REPORT STATUS	TEST	RESULT IN RANGE	RESULT OUT OF RANGE	UNITS	REFERENCE RANGE	SITE CODE
	GLUCOSE		403 H	MG/DL	65-99	
	SODIUM	136		MEQ/L	135-148	
	POTASSIUM	4.2		MEQ/L	3.5-5.5	
	CHLORIDE	100		MEQ/L	99-111	
	CO2	20		MEQ/L	19-31	
	BUN/CREATININE RATIO					
	BUN	10		MG/DL	8-21	
	CREATININE	0.8		MG/DL	0.5-1.4	
	BUN/CREAT (CALC)	12.5		RATIO	10.0-28.0	
	CALCIUM	10.1		MG/DL	8.7-10.5	
	TOTAL PROTEIN	7.4		G/DL	6.2-8.3	
	ALBUMIN	4.4		G/DL	3.8-5.0	
	GLOBULIN (CALC)	3.0		G/DL	2.0-3.8	
	A/G RATIO (CALC)	1.5		RATIO	1.1-2.3	
	BILIRUBIN, TOTAL	0.4		MG/DL	0.1-1.5	
	BILIRUBIN, DIRECT	0.0		MG/DL	0.0-0.3	
	ALK PHOS, TOTAL	84		U/L	27-142	
	AST (SGOT)	30		U/L	1-45	
	ALT (SGPT)			U/L	1-55	
	CHOLESTEROL			MG/DL	(200)	
	TRIGLYCERIDES			MG/DL	37-148	
	HDL CHOLESTEROL			MG/DL	>40	
	LDL CHOL. (CALC)			MG/DL	(130)	
	UNABLE TO CALCULATE LDL DUE TO HIGH TRIGLYCERIDE.					
	CHOL/HDL (CALC)		9.1 H	RATIO		
	MALE REFERENCE :				L <4.8 MOD (6.0) H	
	FEMALE REFERENCE :				L <3.7 MOD <4.7 H	
	LDL/HDL (CALC)			NOTE	RATIO	L <3.0 MOD (6.
	T4, THYROXINE	8.7			UG/DL	4.5-12.5
	T3 UPTAKE		26.5 L	% UPTAKE	27-37	
	FTI (CALCULATION)	7.2			ug/dL	4.6-10.9
	TSH, SERUM (3RD GENERATION)					
	TSH, SERUM	2.60			uIU/mL	0.70-6.40
	CBC W/DIFF					
	WBC	7.0			X10 ³ /CUMM	4.1-11.3
	RBC	5.29			X10 ⁶ /CUMM	3.90-5.50
	HEMOGLOBIN	14.4			GRAMS/DL	12.0-17.0
	HEMATOCRIT	44.6			%	36.0-50.7
	MCV	84			fL	82-103
	MCH	27.2			pq	27.0-34.0
	MCHC	32.3			G/DL	30.9-35.4

left blood on machine 10/18/06

Hg AIC



AT	Quest Diagnostics 1777 Montreal Circle Tucker, GA 30084 (770) 934-9205 Medical Director: W.M. Miller, M.D. Laboratory Director: Pat Ben-Dov	KY	Quest Diagnostics 2277 Charleston Drive Lexington, KY 40505 (606) 299-3868 Medical Director: J. E. Dunnington, M.D.	QSO	Quest Diagnostics 7470 Mission Valley Road San Diego, CA 92108 (619) 686-3000 Medical Director: Daniel Molden, M.D.
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LABORATORY REPORT



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PATIENT PHONE: (562) 777-7414
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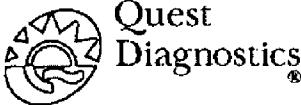
PATIENT NAME			PATIENT ID	ROOM NO.	AGE	SEX	PHYSICIAN
			603-28-5885		19	NG	MARIAN JALIL, M.D.
PAGE	REQUISITION NO.	ACCESSION NO.	LAB REF. #	COLLECTION DATE & TIME	LOG-IN DATE	REPORT DATE	& TIME
		302121562		04/10/2006 NG	04/11/06	04/15/06	2:21AM

REMARKS

FASTING: NO

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REPORT STATUS	FINAL	TEST	RESULT	UNITS	REFERENCE RANGE	SITE CODE
			IN RANGE	OUT OF RANGE		
		RDW	11.4	%	10.8-14.8	
		PLATELET COUNT	312	X10 ³ /CUMM	150-400	
		MPV	8.6	fL	7.1-12.1	
		NEUTROPHILS	58.0	%		
		LYMPHOCYTES	34.2	%		
		MONOCYTES	5.5	%		
		EOSINOPHILS	2.0	%		
		BASOPHILS	0.3	%		
		NUCLEATED RBC'S	0	PER 100 WBC		
		*ABSOLUTE COUNTS (CALC. FROM CBC)				
		ABSOLUTE NEUTROPHILS	4060	CELLS/MCL	1500-7800	
		ABSOLUTE LYMPHOCYTES	2394	CELLS/MCL	850-3900	
		ABSOLUTE MONOCYTES	385	CELLS/MCL	200-950	
		ABSOLUTE EOSINOPHILS	140	CELLS/MCL	15-500	
		ABSOLUTE BASOPHILS	21	CELLS/MCL	0-200	
		ABSOLUTE NUC. RBC	0	CELLS/MCL	0	
		URINALYSIS W/MICRO REFLEX				
		SPECIFIC GRAVITY	1.042 H		1.001-1.035	
		PH	6.0		5.0-8.0	
		GLUCOSE, URINE	3+		NEGATIVE	
		PROTEIN, URINE	NEG		NEGATIVE	
		KETONES	NEG		NEGATIVE	
		OCCULT BLOOD	NEG		NEGATIVE	
		BILIRUBIN	NEG		NEGATIVE	
		LEUKOCYTE ESTERASE	TRACE		NEGATIVE	
		NITRITE	NEG		NEGATIVE	
		URINALYSIS, MICRO				
		COLOR	YELLOW		YELLOW	
		APPEARANCE	CLEAR		CLEAR	
		WBC, URINE	NONE SEEN	PER HPF	0-5	
		RBC, URINE	NONE SEEN	PER HPF	0-3	
		SQUAMOUS EPITHELIAL	0-5	PER HPF	0-5	
		BACTERIA	NONE SEEN	PER HPF	NONE SEEN	
		CAST (HYALINE)	NONE SEEN	PER LPF	NONE SEEN	
		URINE CULTURE				
		SOURCE	URINE			
		STATUS	FINAL			
		RESULT	NO ORGANISMS ISOLATED			



AT	Quest Diagnostics 1777 Montreal Circle Tucker, GA 30084 (770) 934-9205 Medical Director, W.M. Miller, M.D. Laboratory Director, Pat Ben-Dov	KY	Quest Diagnostics 2277 Charleston Drive Lexington, KY 40505 (606) 299-3888 Medical Director, J. E. Dunnington, M.D.	QSD	Quest Diagnostics 7470 Mission Valley Road San Diego, CA 92108 (619) 686-3000 Medical Director: Daniel Molan, M.D.
GA	Quest Diagnostics 508 C, State Parkway Schaumburg, IL 60173 (708) 285-2010 (800) 669-6995 Laboratory Director, E. Staros, M.D.	MI	Quest Diagnostics 5601 Northwest 159th Street Hialeah, FL 33014 (305) 620-0850 Medical Directors, R. Gomez, M.D. D. Economides, M.D.	SF	Quest Diagnostics 6511 Golden Gate Drive Dublin, CA 94568 (825) 828-2500 Laboratory Director, J. Fitzwater, M.D.
CL	Quest Diagnostics 6180 Hallie Drive Valley View, OH 44125 (216) 328-7500 Laboratory Director, C. Hauer, M.D.	ML	Quest Diagnostics 1103 Second Avenue, South Minneapolis, MN 55403 (612) 333-6521 Laboratory Director, Robert Morrison, M.D.	SL	Quest Diagnostics 11636 Administration Drive St. Louis, MO 63146 (314) 567-3905 Laboratory Director, R.L. Patrick, M.D.
DE	Quest Diagnostics 38700 Country Club Drive Farmington Hills, MI 48331 (313) 486-2300 Laboratory Director, K. Shah, M.D.	NO	Quest Diagnostics 4648 I-10 Service Road West Maitland, LA 70001 (504) 889-2307 Medical Director, Carol Sartin, M.D.	TP	Quest Diagnostics 4225 E. Fowler Avenue Tampa, FL 33617 (813) 972-7100 Medical Director, Harvey Kincaid, Ph.D.
EZ	Quest Diagnostics-Nichols Institute 33600 Omega Highway San Juan Capistrano, CA 92690 (800) 553-5445 Laboratory Director, Jerald C. Nelson, M.D.	NS	Quest Diagnostics 2545 Park Plaza Nashville, TN 37203 (615) 327-1955 Medical Director, H. Pribor, M.D., Ph.D.	WD	Quest Diagnostics 7600 Tyrone Avenue Van Nuys, CA 91405 (818) 989-2520 Laboratory Director, Geoffrey H. Moyer, M.D., Ph.D.
HL	Quest Diagnostics 8900 Interchange Drive Houston, TX 77054 (800) 669-6805 Laboratory Director, W. Crawford, M.D.	NW	Quest Diagnostics 1737 Airport Way, Suite 200 Seattle, WA 98134 (206) 623-8100 (800) 877-0051 Medical Director, Michael H. Kalnaski, M.D.	WO	Quest Diagnostics Clinical Trials 7800 Tyrone Avenue Van Nuys, CA 91405 (818) 989-2520 Laboratory Director, Marc S. Edwards, M.D.
IF	Quest Diagnostics 8000 Sovereign Row Dallas, TX 75247 (214) 839-1301 (800) 442-2102 Medical Director, S. Hilton, M.D.	NY	Quest Diagnostics 575 Underhill Boulevard Syosset, NY 11781 (516) 877-3800 Laboratory Directors, J. Daino, M.D.		
IR	Quest Diagnostics 601 N. Frisco San Antonio, TX 78207 (512) 225-5101 Medical Director, Robert Allen, M.D.	PL	Quest Diagnostics 11425 Cornhill Drive Owings Mills, MD 21117 (301) 581-2400 Medical Directors, A. McTighe, M.D. P. Whelan, M.D.		
KP	Quest Diagnostics 900 Business Center Drive Horsham, PA 19044 (800) 825-7330 (215) 957-8300 Medical Director, Herman Hurwitz, M.D.	OPO	Quest Diagnostics 8600 SW Hampton Street Portland, OR 97223 (503) 328-1144 Medical Director, Joel Shilling, M.D.		

Western Area Rapid Response Laboratories

AB	Medical Park Lab, Inc. A Quest Diagnostics Managed Laboratory 2211 East Northern Lights Blvd., Suite 210 Anchorage, Alaska 99508 (907) 272-5475 Laboratory Director: Marcell Jackson, M.D.	CH	Quest Diagnostics 183 East 8th Ave. Chico, CA 95926 (916) 342-0123, (800) 424-4448 (No. CA only) Laboratory Director: John Winfield, M.D.	LKL	Quest Diagnostics 219 East Johnson Chelan, WA 98816 (509) 882-0665 Laboratory Director: Jim Peterson, Ph.D.	TC	Quest Diagnostics 630 N. Alvernon Way Tucson, AZ 85711 (520) 322-8264 Laboratory Director: Osana M.A. Abdellatif M.D.
AT	Quest Diagnostics 1901 South Union #B3005 Tacoma, WA 98405 (253) 572-4331 Laboratory Director: Jim Peterson, Ph.D.	EID	Quest Diagnostics Affiliated With Eastern Idaho Regional Medical Center 3100 Channing Way Idaho Falls, ID 83403 (208) 529-6040 Laboratory Director: Gary Ellwain, M.D.	MC	Quest Diagnostics 1541 Florida Ave., Suite 102 Modesto, CA 95350 (209) 577-1246 Laboratory Director: Roger Vogelzang, M.D.	TE	Quest Diagnostics 5886 Corporate Ave. Cypress, CA 90630 (800) 522-8378 Laboratory Director: Maher Badir, M.D.
AHM	Quest Diagnostics Affiliated With Alaska Regional Hospital 2801 DeBarr Road Anchorage, AK 99508 (907) 264-1123 Laboratory Director: Steven Jayich, M.D.	EV	Quest Diagnostics Affiliated With Evergreen Hospital Medical Center 12040 NE 128th Kirkland, WA 98034 (425) 899-2730 Laboratory Director: Gary Ellwain, M.D.	MH	Quest Diagnostics 3131 Berger Ave. #100 San Diego, CA 92123 (619) 739-6355 Laboratory Director: Daniel Morden, M.D.	VD	Quest Diagnostics Affiliated With Valley Medical Center 400 South 43rd Street Fenton, WA 98055 (425) 251-5160 Laboratory Director: Ira Allen, M.D.
BO	Quest Diagnostics Affiliated With Capital Medical Center 3990 Capital Mall Drive Olympia, WA 98502 (360) 754-5660 Laboratory Director: J. Michael Odell, M.D.	FAB	Quest Diagnostics 1918 Lathrop Fairbanks, AK 99701 (907) 452-1658 Laboratory Director: Jon Conklin, M.D.	RBG	Quest Diagnostics 1236 NW Garden Valley Blvd. Roseburg, OR 97470 (541) 957-2600 Laboratory Director: Raymond Harry, M.D.	WI	Quest Diagnostics 1155 Mission St. SE, Suite 104 Salem, OR 97302 (503) 315-1342 Laboratory Director: Shadab N. Alizai, M.D.
BRM	Quest Diagnostics 2601 Cherry, Suite 208 Bremerton, WA 98310 (360) 406-0814 Laboratory Director: Jim Peterson, Ph.D.	F-B	Quest Diagnostics aka Faculty Medical Laboratory 11370 Anderson St., #2900 Loma Linda, CA 92354 (909) 558-2818 (800) 758-7525 Laboratory Director: Darryl Heustis, M.D.	RMA	Quest Diagnostics 3680 Arlington Ave. Riverside, CA 92506 (909) 886-0671 Laboratory Director: G. William Seukel, M.D.	ZL	Quest Diagnostics 939 Mountain View Dr. # 110 Shelton, WA 98584 (360) 427-7807 Laboratory Director: Joel Shilling, M.D.
BU	Quest Diagnostics 295 West Bullard Clovis, CA 93612 (559) 299-3157 Laboratory Director: Melvin Ankenman, C.L.B.	GSA	Quest Diagnostics Affiliated With Good Samaritan Hospital 407 14th Ave. SE Puyallup, WA 98371 (253) 841-6840 Laboratory Director: Larry O'Bryant, M.D.	SH	Quest Diagnostics 505 E. Romie Lane, # 4 Salinas, CA 93901 (831) 424-1955 Laboratory Director: Ernest Simard, M.D.	ZO	Health Diagnostic Laboratory Managed by Quest Diagnostics 8826 N. 23rd Ave. Phoenix, AZ 85021 (602) 861-7172 Laboratory Director: Jim Little, M.D.
				SM	Quest Diagnostics 101 S. San Mateo, #107 San Mateo, CA 94401 (650) 348-5221 Laboratory Director: Paul Ortega, M.D.		