Nationwide Health Systems BAGUIO, Inc

DATE:_____

CHILD / EDE / APPT
PWD / SENIOR / XSD : _____

Referred by:

a. Self (family/friend/internet)
b. Embassy information
c. Immigration consultant
d. Company / Recruiter

IME/ UMI/ HAP/ NZER: _____

NEW MED / REMEDICAL: _____

PLEASE FILL UP DOTTED BOXED AREA ONLY

PREFERRED PHILIPPINE CONTACT NUMBERS AND ADDRESS:

Cellphone: _____/_____

Email Address: _____

Address: _____

_____

Passport Number: _____ expire in 6 months? (YES/NO)

Other ID: _____

CLIENT INFORMATION:

Last Name: _____

First Name:_____

Middle Name: _____

Age: _____ Gender: _____ Civil Status: _____

Date of Birth: _____ Day / Month / Year

If applicable

Last Menstrual Period: _____ Date Started / Date Ended

Intended Occupation / Activity / Study (Course): _____

a. Is this your or your family's first visa related medical examination? *Please encircle* YES NO

b. Has your or your family's application for a visa ever rejected before? *Please encircle* YES NO

c. **NEW ZEALAND APPLICANTS** INTENDED LENGTH OF STAY? Please encircle **Less than 6 mos / 6 - 12 mos / 12 - 24 mos / more than 24 mos**

VISA CATEGORY Please encircle

I. **RESIDENCE** (Skilled - Business / Pacific Categories / Family / Humanitarian UNHCR / Humanitarian - other)
II. **TEMPORARY** (Visitor / Student / Work with job offer / Work without job offer)
III. **WORK TO RESIDENCE** (Worker / Family Worker)

d. **CANADA APPLICANTS** Did you receive a letter that your application is under review based on the new public policy effective **1 June 2018?** Please encircle YES NO

if **UPFRONT MEDICAL**, what is your VISA CATEGORY? Please encircle **VISITOR STUDENT WORKER (Express Entry)**

e. **AUSTRALIA APPLICANTS** If you are applying for a Temporary visa, do you intend to apply for a permanent stay in Australia with in the next 6 -12 months? Please encircle YES NO

Would you like your health to be assessed "upfront" for a permanent stay in Australia? *Please encircle* YES NO

Do you intend to work or study to be a Nurse / Physician / Dentist / Paramedics? *Please encircle* YES NO

DECLARATION BY EXAMINEE (OR PARENT GUARDIAN IF UNDER 16 YRS OF AGE)

☐ I declare that the information given above are TRUE and CORRECT. _____

Print Name and Sign (Examinee or Accompanying Parent/Guardian if 16 yrs old and below)

Father / Mother / Grandmother / Grandfather / Uncle / Aunt / Guardian / Brother / Sister

Attach recent Photo

FOR NHSBI STAFF ONLY

☐ CPE, Urinalysis, RPR, HIV, Hbsag, Anti-Hcv, FCBC, HBA1C, eGFR, CXR
☐ CPE, Urinalysis, RPR, HIV, Hbsag, full CBC, Crea, LFT, CXR
☐ CPE, Urinalysis, HIV, Hbsag, Anti-HCV, CXR
☐ CPE, Urinalysis, RPR, HIV, CXR
☐ CPE, Urinalysis, HIV, CXR
☐ CPE, Urinalysis, CXR
☐ CPE, Urinalysis
☐ CPE Only

OTHER TESTS

☐ UA - DIPSTICK	☐ LFT	☐ CXR - PA
☐ UA - MICROSCOPY	☐ SGPT	☐ CXR - APL
☐ PREG TEST	☐ FCBC	☐ CXR - APICO
☐ HIV	☐ EGFR	☐ CXR - R LAT
☐ HBSAG	☐ TPPA	☐ CXR - L LAT
☐ ANTI-HCV	☐ UPC	☐ CXR - LOR
☐ FBS	☐ FERRITIN	☐ CXR - R OBL
☐ LIPID PROFILE	☐ ECG	☐ CXR - L OBL
☐ S. CREA	☐ CHEST UTZ	☐ CXR - SPOT
☐ BUA	☐ LGBP UTZ	
☐ AFP		

Others:_____

_____

_____

	TIME IN	TIME OUT	INITIAL
INITIAL INTERVIEW:			
CONSENT:			
SCAN/PICTURE:			
PRE-EXAM:			
CASHIER: CASH/ADV DEPOSIT			
RECEIPT/LOGBOOK			
LABORATORY: URINALYSIS			
BLOOD TEST			
DOH			
ADD'L TEST			
CHEST X-RAY: PA VIEW			
ADD'L VIEW			
HEIGHT AND WEIGHT:			
PHYSICAL EXAM:			
REFERRAL:			
FINAL INTERVIEW: WAITING AREA (2ND FLOOR EXTENSION AREA)			

Pertinent Laboratory Findings: *circle/highlight/add required tests (MARK "N" for NORMAL RESULTS)*

UA RPR HIV HBSAG ANTI-HCV CXR EGFR FCBC HAIC RPT UA CREA ECG LFT LGBP FBS FLIPID _____ _____ _____ _____

Blood Pressure

Initial: _____/_____

Repeat: _____/_____

Body Temp: _____

BMI: _____ Height in cm: _____

Head Circumference: _____ Weight in kg:_____

Uncorrected / Corrected

OS/L _____/_____

OD/R_____/_____

☐ PH
☐ GLASSES
☐ CONTACT LENS

PERTINENT HISTORY OR PHYSICAL EXAMINATION: Recommendations/Comments/Notes

GRADING

A B

MD: _____

SUBMITTED: _____

2019