**Nationwide Health Systems**
**BAGUIO, Inc**

**DATE:**_____

**CHILD / PWD / SENIOR :** _____

**NON-EDE/ XSD / EDE / APPT** _____

**Referred by:**

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

**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 / Christchurch Response 2019 / 2021 Resident Visa)

**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)***

*Please encircle relation to examinee: 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, CREA, CXR**
☐ **CPE, FCBC, EGFR, CXR**
☐ **CPE, Urinalysis, HIV, CXR**
☐ **CPE, Urinalysis, CXR**
☐ **CPE, CXR**
☐ **CPE, Urinalysis**
☐ **CPE Only**

| NHSBI | METRO |
|---|---|
| | |
| | |
| Total Medical Fee | Total Cash Paid |
| Signature | Change |
| Add'l Fee | Add'l Fee |
| Add'l Fee | Add'l Fee |
| Total Add'l Fee | Total Cash Paid |
| Signature | Change |
| TOTAL MEDICAL FEE PAID | |

**DEPOSIT**

**CASH**

**OTHER TESTS**

☐ UA-Dipstick
☐ UA-Microscopy
☐ PREG TEST
☐ HIV
☐ HBSAG
☐ ANTI-HCV
☐ FBS
☐ LIPID PROFILE
☐ S. CREA
☐ BUA
☐ AFP
☐ LFT
☐ SGPT
☐ FCBC
☐ EGFR
☐ TPPA
☐ UPC
☐ FERRITIN
☐ SPUTUM
☐ IGRA
☐ CALCIUM
☐ HBeAG
☐ HBV - DNA
☐ Liver Fibro Scan
☐ ECG
☐ CHEST UTZ
☐ LGBP UTZ
☐ CXR - PA
☐ CXR - APL
☐ CXR - APICO
☐ CXR - R LAT
☐ CXR - L LAT
☐ CXR - LOR
☐ CXR - R OBL
☐ CXR - L OBL
☐ CXR - SPOT
☐ PPD

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: | | | |
| | | | |
| INSTRUCTED: | | | |
| 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 Cir:** _____ **Weight in kg:**_____

**Uncorrected / Corrected**
**OS/L** _____/_____
**OD/R**_____/_____

☐ **PH**
☐ **GLASSES**
☐ **CONTACT LENS**

**PERTINENT HISTORY OR PHYSICAL EXAMINATION: Recommendations/Comments/Notes**

**GRADING** **A** **B**

**SUBMITTED BY:**

_____

_____
**BARCODE**

JAN 2022