FOR HRN -

ARGARITA ISABEL AMOROSO, MD FPOGS FPSUOG

OBSTETRICIAN GYNECOLOGIST/ OB GYN ULTRASOUND SUBSPECIALIST

Fellow, Philippine Obstetrical and Gynecological Society

Fellow, Philippine Society of Ultrasound in Obstetrics and Gynecology

ROOM 206 FABIE GENERAL HOSPITAL

PELAYO/LEGASPI STREET, DAVAO CITY

0933-403-1553/ 0945-825-8357

DATE: May 14 2024
NAME: Calabia Annie Grace
AGE/SEX: 29 Female
ADDRESS:

℞ **SPMC UCW**

Maam Daylen/ Maam Liza

Request: 3d 4d TVS -

Consider Mullerian anomaly

MARGARITA ISABEL AMOROSO, MD, FPOGS, FSUOG
License no.: 108958
PTR No.: 9348385

Republic of the Philippines

Department of Health

Center for Health Development Davao Region

SOUTHERN PHILIPPINES MEDICAL CENTER

Davao City

PATIENT'S IDENTIFICATION CARD

Health Record # 1760820 4

Calabia	Anne Grace	A
Surname	First Name	M.I.

10/22/94	
Date of Birth	Age

Monte

Address

Note: Please bring this to the hospital for every consultation/transaction. In case of loss please pay ₱ 25.00 for new I.D.

MAY 1 6 2024

SPMC-F-HIM-11 Effectivity: October 1, 2013 Rev.:0

SOUTHERN PHILIPPINES MEDICAL CENTER
Department of Obstetrics & Gynecology
ULTRASOUND CENTER FOR WOMEN

INFORMED CONSENT TO TREATMENT OR PROCEDURE

1. I hereby request Dr. _____, and or such assistants or designees may be selected by him/ her, to perform the treatment or procedure(s) requested.
2. The treatment, procedure(s) necessary to treat or diagnose my condition has/ have been explained to me by the above physician, and I understand the nature it to be: TVD

I have been made aware of the benefits, risk, and possible complications that are associated with the treatment, procedure(s) described above, as well as the feasible alternatives, if any.

Date: 5-22-24 9AM

_____
Name and Signature of Patient

SOUTHERN PHILIPPINES MEDICAL CENTER

Institute of Women and Neonatal Health - Department of Obstetrics and Gynecology

ULTRASOUND CENTER FOR WOMEN

OUT PATIENT SERVICES PROCEDURE REQUEST FORM

Please write legibly and complete all the required information

DATE: 5-16-24 HRN: 3608207 OB (__) GYNE (__) LMP: _____ G/P: _____

NAME: Calabia, Annie Grace AGE: 24 ADDRESS: D.C

PATIENT'S HISTORY: _____

PELVIC FINDINGS: _____

INITIAL DIAGNOSIS/IMPRESSIONS: To consider mullerian Anomaly

REQUESTING PHYSICIAN (Please print name and sign) _____

Please put a check mark (/) or highlight the box of the requested procedure

PROCEDURE	CODE	RATE
Biophysical Scoring Single w/o pf	TAS-OB4	450
Biophysical Scoring Single RF	RF-OB4	150
Biophysical Scoring Twins w/o pf	TAS-OB5	900
Biophysical Scoring Twins RF	RF-OB5	300
Biophysical Scoring Triplets w/o pf	TAS-OB6	1350
Biophysical Scoring Triplets RF	RF-OB6	450
Cervical Length/Placental Location	TVS-OB14	350
Cervical Length/Placental Location RF	RF-OB14	150
Congenital Anomaly Scan Single w/o pf	TAS-OB10	1100
Congenital Anomaly Scan Single RF	RF-OB10	700
Congenital Anomaly Scan Twin w/o pf	TAS-OB11	2200
Congenital Anomaly Scan Twin RF	RF-OB11	1400
Congenital Anomaly Scan Triplets w/o pf	TAS-OB12	3300
Congenital Anomaly Scan Triplets RF	RF-OB12	2100
Fetal 3D/4D Face Scan w/o PF	RF-3D/4D	2000
Fetal 3D/4D Face Scan RF	3D4D OB	1300
Gyne 3D/4D Ultrasound w/o pf	3D4D-GYN	3000
Gyne 3D/4D Ultrasound RF	RF-3D4D-G	2000
GYNE DOPPLER W/O PF	TVS-GYN4	1100
GYNE DOPPLER RF	RF-GYN4	700
GYNE ULTRASOUND GUIDED W/O PF	TVS-GYN7	3000
GYNE ULTRASOUND GUIDED RF	RF-GYN7	2000
Gyne USD Guided Paracentesis w/o PF	TVS-GYN8	3000
Gyne USD Guided Paracentesis RF	RF-GYN8	2000
HSSG without PF	TVS-GYN10	17980
HSSG RF	RF-GYN10	2540

PROCEDURE	CODE	RATE
OB DOPPLER w/o PF	TVS-OB7	1100
OB DOPPLER RF	RF-OB7	700
OB DOPPLER TWINS w/o PF	TAS-OB8	2200
OB DOPPLER TWINS RF	RF-OB8	1400
OB DOPPLER TRIPLETS w/o PF	TAS-OB9	3300
OB DOPPLER TRIPLETS RF	RF-OB9	2100
ONCO ULTRASOUND w/o PF	ONCO	1150
ONCO ULTRASOUND RF	RF-ONCO	850
Pelvic Floor Ultrasound w/o PF	TPS	1100
Pelvic Floor Ultrasound RF	RF-TPS	1300
PLACENTAL DOPPLER w/o PF	PDOP	1100
PLACENTAL DOPPLER RF	RF-PDOP	700
Pregnancy Evaluation Single w/o PF	TAS-OB	300
Pregnancy Evaluation Single RF	RF-OB	150
Pregnancy Evaluation Twins w/o PF	TAS-OB1	600
Pregnancy Evaluation Twins RF	RF-OB1	300
Pregnancy Evaluation Triplets w/o PF	TAS-OB2	900
Pregnancy Evaluation Triplets RF	RF-OB2	450
SISH w/o PF	TVS-GYN3	8000
SISH RF	RF-GYN3	2540
Transabdominal Ultrasound w/o PF	TAS-GYN2	350
Transabdominal Ultrasound RF	RF-GYN2	150
Transrectal Ultrasound w/o PF	TRS	350
Transrectal Ultrasound RF	TRS-RF	150
Transvaginal Ultrasound w/o PF	GYN1	350
Transvaginal Ultrasound RF	TVS-GYN	150

REMARKS:

SPMC- OUTPATIENT DEPARTMENT
HEALTH DECLARATION

PATIENT ✓ 16 MAY 2024 WATCHER

Date: Temp: [illegible]
Name: Annie Grace A. Calabia
Address: Purok Mt. Carmel Buhangin D.C
Contact No. 09197432031

Do you have the following symptoms?

	YES	NO
Fever?		✓
Shortness of breath?		✓
Colds?		✓
Dry cough?		✓

VACCINATED: ✓ YES NO

RTPCR/RAT: YES ✓ NO

I hereby certify that all information above is true and correct.

Patient's Signature/Watcher

Assessor