



Patient Name :.....

HN :..... Age :..... Sex :.....

DOB :.....

Collected Date/Time :.....

Female Package

HEMATOLOGY & COAGULATION	IMMUNOLOGY	TUMOR MARKERS	HEAVY METALS
<input type="checkbox"/> CBC	<input type="checkbox"/> C-Reactive Protein (CRP)	<input type="checkbox"/> AFP	<input type="checkbox"/> Lead in blood
<input type="checkbox"/> ESR	<input type="checkbox"/> Rheumatoid Factor (RF)	<input type="checkbox"/> CEA	<input type="checkbox"/> Mercury in blood
<input type="checkbox"/> G-6 PD		<input type="checkbox"/> CA 125	
<input type="checkbox"/> ABO grouping		<input type="checkbox"/> Serum Ferritin	
		<input type="checkbox"/> CA-19	

CHEMISTRY	HORMONES	INFECTIOUS MARKERS	MICROSCOPIC
O Diabetes Profile	<input type="checkbox"/> Free T3	O HBV Profile	<input type="checkbox"/> Urinalysis
<input type="checkbox"/> Blood Glucose	<input type="checkbox"/> TSH	<input type="checkbox"/> HBs Ag	<input type="checkbox"/> Stool Exam & Occult blood
<input type="checkbox"/> HbA1C	<input type="checkbox"/> T4	<input type="checkbox"/> Anti-HBs	
O Lipid Profile	<input type="checkbox"/> Estrone (E1)	<input type="checkbox"/> Anti-HBc	
<input type="checkbox"/> Triglyceride	<input type="checkbox"/> FSH		
<input type="checkbox"/> HDL-C	<input type="checkbox"/> LH	<input type="checkbox"/> Anti-HIV	
<input type="checkbox"/> LDL-C	<input type="checkbox"/> Progesterone		
<input type="checkbox"/> Total Cholesterol	<input type="checkbox"/> Testosterone		
O Renal Function Test	<input type="checkbox"/> DHEAS		
<input type="checkbox"/> BUN	<input type="checkbox"/> Cortisol		
<input type="checkbox"/> Creatinine			
<input type="checkbox"/> Uric Acid			

O Liver Function Test

	ANTI-OXIDANTS	OTHER
<input type="checkbox"/> Total Protein		
<input type="checkbox"/> Albumin	<input type="checkbox"/> Vitamin B12	<input type="checkbox"/>
<input type="checkbox"/> Globulin	<input type="checkbox"/> Vitamin D2/D3	<input type="checkbox"/>
<input type="checkbox"/> Total Bilirubin		
<input type="checkbox"/> Direct Bilirubin		
<input type="checkbox"/> AST (SGOT)		
<input type="checkbox"/> ALT (SGOT)		

- Calcium
- Inorganic Phosphorus
- Serum Amylase

*Please provide all diagnostics other than blood test (X-Ray, EKG, CT Scan, MRI, Sonogram & etc) if available & done within the last year
 *Please state and provide any previous medical history or medical records.