

12. Radiology Services

12.1 Ultrasound Services for Inpatient and Outpatient

This service provides various ultrasound examinations for In-patients and Out-patients on a scheduled basis. Availability of service is 8:00 am to 12:00 noon, Tuesday and Friday.

Office or Division:	St. Paul Hospital			
Classification:	Simple			
Type of Transaction:	Government-to-Citizen			
Who may avail:	All Patients (by appointment)			
CHECKLIST OF REQUIREMENTS			WHERE TO SECURE	
1. 1 Original X-ray Request Form			Prescribing Doctor	
CLIENT STEPS	AGENCY ACTIONS	FESS TO BE PAID	PROCESSING TIME	PERSON RESPONSIBLE
1. Present the ultrasound request form.	1. Receive patient's request form.	None	1 minute	<i>Radiologic Technologist</i> St.Paul Hospital
If unable to pay, proceed to Medical Social Service for patient classification and financial assistance prior to payment.	1.1. Check for completeness of data.	None	1 minute	
	1.2. Indicate the examination fee on the request form and give the necessary instructions for the payment.	Ultrasound Fee Summary (see table below)	2 minutes	

2. Provide data. Patient Name, Age, Gender, Address, Birthdate, Contact Number, Last Menstrual Period for women within reproductive age.	2. Record the patient's data on the receiving logbook and give patient instruction and schedule of examination.	None	5 minutes	<i>Radiologic Technologist</i>
3. Wait until name is called for the requested ultrasound procedure.	3. Call the patient for an ultrasound procedure.	None	3 minutes	<i>Radiologic Technologist</i>
3.1. Submit self for ultrasound procedure.	3.1. Perform the requested Ultrasound procedure.	None	20 minutes	<i>Radiologist</i> St. Paul Hospital
3.2. Wait for the ultrasound result.	3.2. Encode the ultrasound report.	None	15 minutes	<i>Radiologist</i> St. Paul Hospital
4. Releasing of ultrasound result.	4. Release the ultrasound result of out-patient and give the result of in-patient to the nurse station.	None	5 minutes	<i>Radiologic Technologist</i> St. Paul Hospital

	Total	Refer to Applicable Charges	52 minutes	
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ULTRASOUND SECTION SCHEDULE OF FEE

PROCEDURE	FEE	PROCEDURE	FEE
ANY SINGLE ORGAN	500.00	LOWER ABDOMEN	700.00
BIOPHYSICAL PROFILE (BPS)	800.00	PELVIS NON-GRAVID	600.00
CHEST	350.00	PELVIS GRAVID	550.00
CRANIAL	650.00	TRANSVAGINAL (TVS)	800.00
HEPATOBIILIARY TREE (HBT)	600.00	UPPER ABDOMEN	1,000.00
KIDNEYS	600.00	WHOLE ABDOMEN	1,200.00
KUB	750.00	THYROID	500.00

KUB & PROSATE / KUB & PELVIS	750.00		NECK	600.00
LIVER	500.00		TESTICULAR	500.00
SOFT TISSUE	500.00		BREAST	600.00

12. 2 X-ray Services for Inpatient

The X-ray In-Patient services shall provide quality radiographic images and accurate results of the diagnostic services offered ensuring utmost safety of the patient all throughout the performance of the procedure.

This service provides routine diagnostic x-ray imaging for In-patients. Availability of service is 24 hours, Monday to Sunday.

Office or Division:	St. Paul Hospital			
Classification:	Complex			
Type of Transaction:	Government-to-Citizen			
Who may avail:	All In-Patients needing general x-ray services			
CHECKLIST OF REQUIREMENTS			WHERE TO SECURE	
X-ray Request Form (1 original)			Prescribing Doctor	
CLIENT STEPS	AGENCY ACTIONS	FESS TO BE PAID	PROCESSING TIME	PERSON RESPONSIBLE
1. Present the x-ray request form.	1. Receive patient's x-ray request form. 1.1. Check for completeness of data.	None	1 minute	<i>Radiologic Technologist</i> St. Paul Hospital
		None	1 minute	

2. Provide data. Patient Name, Age, Gender, Address, Birthdate, Contact Number, Last Menstrual Period for women within reproductive age.	2. Encode the patient's data on the receiving logbook and on the system.	None	3 minutes	<i>Radiologic Technologist</i> St. Paul Hospital
3. Wait until name is called for the requested x-ray procedure.	3. Call patient for x-ray procedure. (None	3 minutes	<i>Radiologic Technologist</i> St. Paul Hospital
3.1. Submit self for x-ray procedure.	3.1. Perform the requested x-ray procedure.			
3.2. Get a schedule of x-ray results.	3.2. Do the final reading.	None	10 minutes	<i>Radiologic Technologist</i> St. Paul Hospital
			2 days	

		None		
4. Releasing x-ray results.	4. Release the x-ray results of ward patients to the nurse station.	None	5 minutes	<i>Radiologic Technologist</i> St. Paul Hospital
4.1. Sign the logbook.	4.1. Let the Nurse on duty sign the releasing logbook for in-patient.	None	2 minutes	
	Total	Refer to applicable charges	2 days, 25 minutes	

12. 3 X-ray Services for Out-Patient

The X-ray Out-Patient services shall provide quality radiographic images and accurate results of the diagnostic services offered ensuring utmost safety of the patient all throughout the performance of the procedure.

This service provides routine diagnostic x-ray imaging for outpatient department patients. Availability of service is 24 hours, Monday to Sunday.

Office or Division:	St. Paul Hospital			
Classification:	Complex			
Type of Transaction:	Government-to-Citizen			
Who may avail:	All Out-Patients needing general x-ray services			
CHECKLIST OF REQUIREMENTS		WHERE TO SECURE		
1. 1 Original X-ray Request Form		Prescribing Doctor		
2. 1 Original Official Receipt		Cashier Section		
3. MSS Approval/ Acknowledgment (if applicable)		Medical Social Worker		
If by an Authorized Representative				
1. 1 Valid Identification Card (photocopy of the patient)		Patient		
2. Authorization Letter from the patient		Patient		
CLIENT STEPS	AGENCY ACTIONS	FESS TO BE PAID	PROCESSING TIME	PERSON RESPONSIBLE
1. Present the x-ray request form.	1.1. Receive patient's x-ray request form.	None	1 minute	<i>Radiologic Technologist</i> St. Paul Hospital
If unable to pay, proceed to Medical Social Service for patient classification and financial assistance prior to payment	1.2. Indicate the x-ray fee on the charge slip and give the necessary instructions for the payment.	None X-ray Fee Summary	2 minutes	

		(see table below)		
2. Pay the indicated amount on the charge slip at the Cashier/show medical social worker approval/acknowledgment. 2.1. Get the receipt.	2. Ask for the charge slip. 2.1. Receive the payment/MSS Approval/MSS Acknowledgment. Issue the official receipt	None	10 minutes	<i>Cashier Staff</i> St. Paul Hospital
		X-ray Fee Summary (see table below)	2 minutes	
3. After Cashier, go back to X-ray Section and present the official receipt. 3.1. 2. Provide data. Patient Name, Age, Gender, Address, Birthdate, Contact Number, Last Menstrual Period for women within reproductive age.	3. Ask for the official receipt. 3.1. Encode the patient's data on the receiving logbook and on the system.	None	1 minute	<i>Radiologic Technologist</i> St. Paul Hospital
		None	3 minutes	
4. Wait until name is called for the requested x-ray procedure. 4.1. Submit self for x-ray procedure. 4.2. Get a schedule of x-ray results	4. Call patient for x-ray procedure. 4.1. Perform the requested x-ray procedure.	None	3 minutes	<i>Radiologic Technologist</i> St. Paul Hospital
		None	10 minutes	

	4.2. Inform the patient when to return for the official result. Instruct to bring the official receipt upon claiming the result.	None	2 minutes	
	4.5. Do the final reading	None	2 days	
5. Claim the x-ray result and present the official receipt.	5. Release the x-ray result to the patient.	None	3 minutes	<i>Radiologic Technologist</i> St. Paul Hospital
	Total	Refer to applicable Charges	2 days, 38 minutes	

XRAY SECTION SCHEDULE OF FEES AND CHARGES

1. SKULL	FEE	4. VERTEBRAL COLUMN	FEE	6. LOWER EXT.	
FACIAL BONE	350.00	CERVICAL SPINE	300.00	FEMUR (THIG)	350.00
MANDIBLE	300.00	THORACIC SPINE	430.00	FOOT	350.00
NASAL BONE	300.00	LUMBAR SPINE	400.0	KNEE/ PATELLA	350.00

ORBIT	450.00	SACRUM/ COCCYX	195.00	TIBIA/FIBULA(LEG)	350.00
PNS	410.00	SCOLIOTIC SERIES	750.00	PELVIS/HIP	350.00
SKULL AP/L	350.0	5.UPPER EXTREMITIES		<p>Note: For UPPER/ LOWER EXTREMITIES PROCEDURES.</p> <p>Price indicated are subject to one side of the body only. We will charge double of the price if both sides (RIGHT AND LEFT) we're indicated in the x-ray request.</p>	
TMJ	350.00	CLAVICLE	300.00		
SKULL WATER'S VIEW	250.00	ELBOW	310.00		
2. THORACIC		FOREARM	290.00		
APICOLORDOTIC VIEW	175.00	HAND	300.00		
CHEST APL/ PAL ADULT	300.00	HUMERUS	320.00		
CHEST APL/ PAL PEDIA	175.00	SHOULDER	290.00		
CHEST PA/ CHEST AP	230.00	WRIST	300.00		
3. ABDOMEN		6.LOWER EXTREMITIES			
ABDOMEN AP	400.00	ANKLE	350.00		