مركز أوركيد الطبي
ORCHID MEDICAL CENTER

File No#: 1000291 Date: 15/3/2018

Patient Name: Dana Eez Aldin :اسم المريض

Date of Birth (تاريخ الميلاد): 18/11/1998 Gender (الجنس) : M / F

Nationality (الجنسية): syrian Occupation (الوظيفة): -

Marital Status (الحالة الاجتماعية): Married Phone No. ((رقم الهاتف: 0547434945

E.MAIL : amgad5555amgad gmail .com

How Did You Know About Us? Dr. EMAN

Weight: 62.50 kg Height: 173cm Blood Type: _____ BP: 110/70

Chief Complaint: _____

Medical History السجل الطبي

Diseases: / Medication: /

Allergies: / Pregnancy: Lmp = 8-12-2017

Hospitalization: / Family History: 15-9-2018

Habits: Smoking: Y/N Alcohol: Y/N Drugs: Y/N

Remarks: G2P1A0 → NVD

Clinical Findings: _____

Radiography: _____

Examination : _____

Diagnosis: _____

د. لميس عبد الحميد عبد المجيد
Dr. Lamees Abdulhameed Abdulmajeed
اخصائي نساء وولادة
Specialist - OBS / GYN
MOH License No.: 7261 ترخيص رقم:
Orchid Medical Centre مركز اوركيد الطبي

Lmp = 8 - 12 - 2017
EDD = 15 - 9 - 2018 → U/S 22 - 9 - 2018
sex = 20 - 9 - 2018

DATE	GA	ULTRA SOUND	WT	BP	BLOOD TEST
15/3/2018	$13^{+2}/52$	SVF, pl. ant., fm+n ? ♂	83.50	110/70	- Early iron - pregnacare
29/4/2018	19/52	SVF, Adeq. l.q. ♂	66.80	110/60	
		fm+h, wt 268 g			
			CBC		
			RBS		

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

DOCTOR NOTE

REDAD DATA

cAEAIOEBAA83ODQxO

Public Data Readed Succ

SHOW READED DATA

Confirm Data

Public Data Verification report

File	Valid Signature?
Non-Modifiable Data (SF3)	False
Modifiable Data (SF5)	False
Holder Signature Image (SF7)	False
Photography	False
Home Address	False
Work Address	False

Card Holder Information

Name	Dana,Fouad,,,Eez Aldin	**IDN:**	784199883795488	**Mother Name:**	
Name (Ar)	دانا,فؤاد,,,عز الدين	**Card Number:**	084533714	**Mother Name (Ar):**	
Title:		**Nationality:**	SYR	**Family ID:**	
Title (Ar):		**Nationality (Ar):**	الجمهورية العربية السورية		
Issue Date:	24/07/2017	**Sex:**	F	**Sponsor Type:**	03
Expiry Date:	18/07/2020	**Date of Birth:**	18/11/1998	**Sponsor Name:**	امجد يحيى العنداري
Marital Status:	02	**Husband IDN:**		**Sponsor Number:**	10977070
Residency Type:	03	**Residency Number:**	30120173015958	**Residency Expiry:**	18/07/2020
ID Type:	IL	**Occupation:**	99	**Occupation Field:**	00

Photo

Signature Image

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

Medical Consent Form

I hereby consent and authorize the doctor to treat my medical condition, which has been explained to me by the qualified physician.

I understand that in order to provide me with the most efficient and enhanced service, diagnostic and other procedures may be deemed necessary.

I understand that my treating doctor may discover other or different conditions, which may require additional or different procedures than those planned.

I authorize my treating doctor to perform such procedure, which are advisable in their professional judgment.

I understand that no warranty or guarantee has been made to me as to a result or cure just as there may be risks and hazards in continuing my present condition without treatment, there are also risk and hazards to the performance of the diagnostic and /or surgical procedure. I realize that common surgical or diagnostic procedure are potential for an infection, swelling, bleeding and allergic reaction.

I understand that there are minimal fees to be paid per service and that all fees must be paid in full after the completion of each treatment.

I understand that any information that I provide regarding my medical status will be kept completely confidential and anonymous.

I believe that I have sufficient information to give this consent. I certify that form has been fully explained to me and that I have read it understand its contents.

Patient Signature/ Guardian (In case of minors):

Date:

Dentist Signature:

نموذج إقرار طبي

- اوافق و اسمح للطبيب بعلاج حالتي المرضية والتي تم شرحها لي من قبل الطبيب المختص و المؤهل.
- أتفهم انه من أجل تزويدي بالعلاج الأمثل و الخدمة الأفضل، فإن بعض التشخيصات و الاجراءات الطبية الاضافية سوف تكون ضرورية لاستكمال العلاج.
- وأنا أتفهم أن من الممكن ان يكتشف الطبيب خلال العلاج حالات أخرى أو مختلفة عن ما ذكر في الفحص الاولي، والتي قد تتطلب إجراءات إضافية أو مختلفة عن تلك المخطط لها.
- أفوض الطبيب المعالج بإجراء العلاجات اللازمة و المطلوبة بحكم خبرتهم المهنية و العلمية.
- أتفهم أنه ليس هنالك أي ضمانات او أي تأمين لنتائج العلاج كما أتفهم ان هناك مخاطر ناتجة عن عدم استكمال علاج حالتي المرضية، و اتفهم تماما كافة الاخطار الناجمة عن الفحوصات و الاجراءات العلاجية و الجراحية. و اتفهم احتمالية حدوث عدوى أو تورم أو نزيف أو حساسية نتيجة للفحص أو الإجراء الطبي
- أتفهم ان هناك رسوم بالحد الادنى يجب دفعها مقابل الخدمة العلاجية و أن جميع الرسوم المطلوبة يجب سدادها مباشرة بعد الانتهاء من كل علاج.
- إن أي معلومات أقدمها بخصوص حالتي الصحية ستبقى سرية تماما ولا يمكن الاطلاع عليها دون موافقتي.
- أقر أني امتلك المعلومات الكافية لتوقيع هذا الاقرار. و ان هذا النموذج قد تم شرحه لي بالكامل و اني قد قرأت و فهمت جميع تفاصيل هذا الاقرار.

توقيع المريض / الوصي :

التاريخ:

توقيع الطبيب المختص:

DAR AL HIKMAH
Medical Laboratory
مختبر دار الحكمة الطبي

Clinic File No.: 100029

Lab File No.:

Lab No.:

TEST REQUEST FORM

Name : DANA EEZ ALDIN
DOB/Age : 18/11/1998
Gender : ☐ Male ☒ Female
Nationality : SYRIAN
Mob No.:
E-mail : info@omc1.ae
Report Send to : info@omc1.ae

Specimen Collection Date: 30/04/2018 Time 12:10PM
Fasting ☐ Yes ☒ No
Pregnency ☐ Yes Week ☐ No
Ref. Doctor: DR. EMAN
Ref. Clinic : ORCHID MEDICAL CENTER
Insurance Company:
Insurance No. :

Clinical Details :

	BIOCHEMISTRY	
☐	Albumin	S
☐	Aldosterone	S
☐	Alkaline Phosphatase	S
☐	ALT (SGPT)	S
☐	Amylase (Total / Pancreatic)	S
☐	AST (SGOT)	S
☐	Bicarbonate (HCO3)	S
☐	Bilirubin (Total / Direct / Indirect)	S
☐	BNP	S
☐	Calcium (Total / Ionized)	S
☐	Chloride	S
☐	Cholesterol (HDL / LDL)	S
☐	Cholesterol, Total	S
☐	CK	S
☐	CK-MB	S
☐	Creatinine	S
☐	Creatinine Clearance	S+24U
☐	Ferritin	S
☐	Folate (Folic Acid)	S
☐	GGT	S
☐	Glucose (Fasting / Random / PP)	NF
☐	Glucose Tolerance Test	NF
☐	HbA1c	E
☐	Iron	S
☐	LD (LDH)	S
☐	Magnesium	S
☐	Phosphorous	S
☐	Potassium	S
☐	Protein Electrophoresis	S
☐	Protein Total	S
☐	Sodium	S
☐	TIBC	S
☐	Transferrin	S
☐	Triglyceride	S
☐	Troponin	S
☐	Urea	S
☐	Uric Acid	S
☐	Vitamin B12	S
☐	Vitamin D Total (D2+D3)	S
	TUMOR MARKERS	
☐	AFP	S
☐	Ca 125	S
☐	CA 15-3	S
☐	CA 19-9	S
☐	CEA	S
☐	PSA (Free / Total)	S

	HORMONES	
☐	17-OH-Progesterone	S
☐	ACTH	S
☐	Anti-Tg Antibodies	S
☐	Beta HCG	S
☐	Cotisol (AM / PM / R)	S
☐	DHEA-S	S
☐	Estradiol (E2)	S
☐	Estriol (E3)	S
☐	FSH	S
☐	Growth Hormone	S
☐	Insulin (Fasting / PP/1hr/Random)	S
☐	LH	S
☐	Parathyroid hormone (PTH)	EP
☐	Progesterone	S
☐	Prolactin	S
☐	SHBG	S
☐	T3 (Free / Total)	S
☐	T4 (Free / Total)	S
☐	TBG	S
☐	Testosterone (Free / Total)	S
☐	Thyroglobulin (Tg)	S
☐	TSH	S
	HAEMATOLOGY	
☐	APTT	C
☐	Blood Group	E
☐	CBC	E
☐	Coomb's Test (Direct / Indirect)	E/S
☐	D- Dimer	C
☐	ESR	E
☐	Fibrinogen	C
☐	G6PD	E
☐	Hb. Electrophoresis	E
☐	Lupus Anticoagulants	C
☐	Malaria Smear	E
☐	Prepheral Blood Smear	
☐	PT & INR	C
☐	Reticulocytes	E
☐	Rh. Antibody	S
☐	Sickle Cell	E
	SEROLOGY & VIROLOGY	
☐	ASO	S
☐	Anti Sperm Antibodies	Se/S
☐	Anti Transglutaminase IgA	S
☐	Brucella (IgG / IgM)	S
☐	Chlamydia Abs. (IgM / IgG)	S
☐	Chlamydia Ag	U/SW

☐	CMV (IgM / IgG)	S
☐	CRP	S
☐	EBV (IgG / IgM)	S
☐	H. pylori (Ag / Ab)	S/ST
☐	HAV (Total / IgM)	S
☐	HBc (IgM)	S
☐	HBe (Ag / Ab)	S
☐	HBs Ag	S
☐	HBs Ab	S
☐	HIV Combi	S
☐	HSV I (IgG / IgM)	S
☐	HSV II (IgG / IgM)	S
☐	HCV Abs.	S
☐	IgA / IgG / IgD / IgM	S
☐	Measles (IgG / IgM)	S
☐	Monospot	S
☐	RF	S
☐	Rubella (IgG / IgM)	S
☐	Toxoplasma (IgG / IgM)	S
☐	TPHA	S
☐	Vericella Zoster (IgG / IgM)	S
☐	VDRL	S
☐	Widal Test	S
	MICROBIOLOGY	
☐	Ear Swab C / S	SW
☐	Eye Swab C / S	SW
☐	Gram Stain	
☐	HVS C / S	SW
☐	Nasal Swab C / S	SW
☐	Semen C / S	SE
☐	Stoot C /S	ST
☐	Throat Swab C / S	SW
☐	Urethral Discharge C / S	SW
☐	Urine C / S	U
☐	Wet Film (HVS-Urine)	
☐	Wound & Pus C / S	SW
☐	ZN stain for AFB	
	STOOL & URINE	
☐	Occult Blood (Stool)	ST
☐	Rotavirus (Stool)	ST
☐	Stool Routine	ST
☐	Urine Routine	U
	SEMEN ANALYSIS	
☐	Semen CASA	SE
☐	Semen Fructose	SE
☐	Semen Routine	SE

	ALLERGY TESTING	
☐	Allergy (Food / Inhalant / Paediatric)	S
☐	IgE	S
	PROFILES	
☐	Anemia Profile I	
☐	Anemia Profile II	
☐	Antenatal Screen Profile	
☐	Diabetes Profile	
☐	Double Test Profile	
☐	Fertility Profile- Female	
☐	Fertility Profile- Male	
☐	General Health Profile	
☐	Hepatitis B Full Profile	
☐	Hirustism Profile I	
☐	Hirsutism Profile II	
☐	Kidney Function Test	
☐	Lipid Profile I	
☐	Lipid Profile II	
☐	Liver Function Test	
☐	Menopausal Profile	
☐	Osteoporosis Profile	
☐	Ovarian Function Profile	
☐	Primary Health Profile	
☐	Prostate Profile	
☐	Recurrent Abortion Profile	
☐	Thyroid Profile I	
☐	Thyroid Profile II	
☐	TORCH IgG Profile	
☐	TORCH Ig M Profile	
☐	Triple Test Profile	
☐	Others	

SW - Swab
EP - EDTA Plasma
S-Serun
24U - 24 hrs Urine
E - EDTA blood
NF - Sodium Floride
U - Urine
Se - Semen
C-Citrate Blood
St. - Stool / Faeces

Specimen Receiving Date : ..... Time ..... ☐ AM ☐ PM

Flat 203, Union National Bank Bldg, Al Buhaira Cornish St., Al Majaz, P.O. Box 65238, Sharjah, U.A.E.
Tel.+971 6 551 9916, Fax: +971 6 551 9917, E-mail: info@dhmlab.com, Website: www.dhmlab.com

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

Patient Name: **FILE NO#**

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
25/3/2018	consultation + u/s	150	0	[signature]
29/4/2018	consultation + u/s	150	0	[signature]
30/4/2018	CBC + RBS	100.00	0	

DAR AL HIKMAH
Medical Laboratory
مختبر دار الحكمة الطبي

Name	: **Dana Eez Aldin**	Clinic File No.	: **100291**
Sex	: **Female**	Lab File No.	: **1804-03309**
Date Of Birth	: **19 Y**	Lab. Case No.	: **35767**
Referred By	: **Dr. Eman**	Clinic Name	: **Orchid Medical Center**
Receiving Date	: **APR-30-18 01:38 PM**	Reporting Date	: **APR-30-18 03:31 PM**
Insurance Company	:	Insurance No.	:
Indication	:		

CLINICAL CHEMISTRY

Test	Result	Unit	Reference Range	Methodology
Glucose, Random	78.0	mg/dL	Non pregnant: 60 - 140 Pregnant: 60 - 105	

Sample Type *NaF-Plasma*

End of Report

* Samples are processed on the same day of request unless indicated
* Results reported are for the samples received and reference range is age related when applicable

Analysed by : Mona Ibrahim Shubair

License T39021

Printed by : **Er-Fe Heart Balinait**

P.O. Box: 65238 Sharjah - U.A.E. DAR AL HIKMAH MEDICAL LAB

Final Report
Page 1 of 1

Verified by : Dr. Mona Mohamed Hagras
Clinical Pathologist
License No : D42240

Printed on : APR-30-18 05:17 PM

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DAR AL HIKMAH
Medical Laboratory
مختبر دار الحكمة الطبي

Name	: **Dana Eez Aldin**	Clinic File No.	: **100291**
Sex	: **Female**	Lab File No.	: **1804-03309**
Date Of Birth	: **19 Y**	Lab. Case No.	: **35767**
Referred By	: **Dr. Eman**	Clinic Name	: **Orchid Medical Center**
Receiving Date	: **APR-30-18 01:39 PM**	Reporting Date	: **APR-30-18 03:31 PM**
Insurance Company	:	Insurance No.	:
Indication	:		

HEMATOLOGY & COAGULATION

Complete Blood Count

Test	Result		Unit	Reference Range	Methodology
Haemoglobin	**11.2**	L	g/dL	12.3 - 15.3	
Haematocrit (Hct)	**33.0**	L	%	35.0 - 47.0	
Erythrocyte Count (RBC)	**3.7**	L	10^6/mm3	4.1 - 5.1	Automated cell counter
MCV	89		µm^3	80 - 96	
MCH	30		pg	28 - 33	
MCHC	34		g/dL	33 - 36	Automated cell counter
RDW	14.6	H	%	< 14	
Platelet Count	224		10^3/mm3	140 - 392	Automated cell counter
Leucocyte Count (WBC)	9.3		10^3/mm3	4.4 - 11.3	Automated cell counter
Differential Count					
Neutrophils	63		%	40 - 75	
Lymphocytes	28		%	20 - 45	
Monocytes	8		%	2 - 10	
Eosinophils	1		%	0 - 5	
Basophil	0		%	0 - 1	

Sample Type : EDTA BLOOD

End of Report

* Samples are processed on the same day of request unless indicated
* Results reported are for the samples received and reference range is age related when applicable

P.O. Box: 65238
Sharjah - U.A.E.
DAR AL HIKMAH MEDICAL LAB
مختبر دار الحكمة الطبي

Mona

Analysed by : Mona Ibrahim Shubair

License T39021

Printed by : Er-Fe Heart Balingit

Final Report
Page 1 of 1

Verified by : Dr. Mona Mohamed Hagras
Clinical Pathologist
License No : D42240

Printed on : APR-30-18 05:18 PM

مركز اوركيد الطبي
ORCHID MEDICAL CENTER

AED 150.00	RECEIPT VOUCHER (No.REC-000561)	Date:29-04-2018
Receive from Mr./Mrs./M/s. **1000291 - Dana Eez Aldin - 971556316375**		
The sum of Dhs. **One Hundred Fifty Only**		
By Cash **150.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**		
Bank:	Cheque No.	Date: **29-04-2018**
Being		
Made by **Ghada**		

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e – mail : info@omc1.ae
www.omc1.ae

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 100.00	RECEIPT VOUCHER (No.REC-000565)	Date:30-04-2018
Receive from Mr./Mrs./M/s. **1000291 - Dana Eez Aldin - 971556316375**		
The sum of Dhs. **One Hundred Only**		
By Cash **100.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**		
Bank:	Cheque No.	Date: **30-04-2018**
Being		
Made by ~~Ghada~~ KC		

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