مـركـز أوركـيـد الـطـبـي
ORCHID MEDICAL CENTER

File No#: 1000491 | Date: 30/04/18

Patient Name: NURSULU MESSAGGI اسم المريض:

Date of Birth (تاريخ الميلاد): 06/09/1975 | Gender (الجنس): M / (F)

Nationality (الجنسية): KAZAKSTAN | Occupation (الوظيفة):

Marital Status (الحالة الاجتماعية): | Phone No. ((رقم الهاتف: 0551127377

E.MAIL: N.SARBALINA@YAHOO.COM

How Did You Know About Us?

PETROFAC

Weight: | Height: | Blood Type:

Chief Complaint: missed period for 10 days

Medical History السجل الطبي

Diseases: / | Medication: /
Allergies: / | Pregnancy: /
Hospitalization: / | Family History: /

Habits: Smoking: Y/(N) | Alcohol: Y/(N) | Drugs: Y/(N)

Remarks: /

Clinical Findings:

Radiography: /

Examination : /

Diagnosis: missed period for 10 days

BHCG = negative → pt. informed

د. إيمان محسن علي
Dr. Iman Mohsin Ali
ممارس عام - ممارس عام
General practitioner
MOH License No.: D21329 ترخيص رقم
Orchid Medical Centre مركز اوركيد الطبي

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 الفحصوصات 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:

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	Nursulu,,,,Messaggi	**IDN:**	784197530427141	**Mother Name:**	Galiya
Name (Ar)	نور سولو,,,,مساجي	**Card Number:**	073732397	**Mother Name (Ar):**	جاليا
Title:		**Nationality:**	KAZ	**Family ID:**	
Title(Ar):		**Nationality (Ar):**	كازاخستان		
Issue Date:	21/06/2015	**Sex:**	F	**Sponsor Type:**	08
Expiry Date:	16/06/2018	**Date of Birth:**	06/09/1975	**Sponsor Name:**	بتروفاك انترناشيونال (ا-ع-م) ذ م م
Marital Status:	02	**Husband IDN:**		**Sponsor Number:**	00
Residency Type:	07	**Residency Number:**	30120127052703	**Residency Expiry:**	16/06/2018
ID Type:	IL	**Occupation:**	2145	**Occupation Field:**	15

Photo

Signature Image

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

PATIENT NAME: NUASUCU MESSAGGI **FILE NO#:** 1000491

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
30/04/18	B-HCG	120.00	Ø	

DAR AL HIKMAH
Medical Laboratory
مختبر دار الحكمة الطبي

Clinic File No.: 1000471

Lab File No.:

Lab No.:

TEST REQUEST FORM

Name : NURSULU MESSAGGI
DOB/Age : 06/09/1975
Gender : ☐ Male ☑ Female
Nationality : KAZAKSTAN
Mob No.:
E-mail : info@omc1.ae
Report Send to : info@omc1.ae

Specimen Collection Date: 30/4/18 Time 12 NOON
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
☐ Stool 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

DAR AL HIKMAH
Medical Laboratory
مختبر دار الحكمة الطبي

Laboratory Analysis Report

Name	:Nursulu Messaggi	Clinic File No.	: 1000491
Sex	:Female	Lab File No.	: 1804-03308
Date Of Birth	:42 Y	Lab. Case No.	: 35766
Referred By	:Dr. Eman	Clinic Name	: Orchid Medical Center
Receiving Date	:APR-30-18 01:02 PM	Reporting Date	: APR-30-18 01:43 PM
Insurance Company	:	Insurance No.	:
Indication	:		

HORMONES /ENDOCRINOLOGY

Test	Result	Methodology
BHCG qualitative	Negative	
Sample Type *Serum*		

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

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

Final Report

Printed by : Er-Fe Heart Balinqit

Printed on : APR-30-18 01:50 PM

Flat 203, Union National Bank Bldg, Al Buhaira Cornich St., Al Majaz, P.O. Box: 65238, Sharjah, U.A.E
Tel :+971 6 551 9916, Fax : +971 6 551 9917, E-mail: daralhikmah2012@gmail.com

مـركــز أوركـــيـد الــطـبـي
ORCHID MEDICAL CENTER

AED 120.00	RECEIPT VOUCHER (No.REC-000563)	Date:30-04-2018
Receive from Mr./Mrs./M/s. **1000491 - Nursulu Messaggi - 971551127377**		
The sum of Dhs. **One Hundred Twenty Only**		
By Cash **0.00** / By Credit Card **120.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**		
Bank:	Cheque No.	Date: **30-04-2018**
Being		
de by ~~Ghada~~ KC		

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

DAR AL HIKMAH
Medical Laboratory
مختبر دار الحكمة الطبي

Laboratory Analysis Report

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Sex	: Female	Lab File No.	: 1804-03308
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Insurance Company	:	Insurance No.	:
Indication	:		

HORMONES /ENDOCRINOLOGY

Test	Result	Methodology
BHCG qualitative	Negative	
Sample Type *Serum*		

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Analysed by : **Mona Ibrahim Shubair**
License T39021

Final Report
Page 1 of 1

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

Printed by : Er-Fe Heart Balinqit

Printed on : APR-30-18 01:50 PM

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