مركز أوركيد الطبي
ORCHID MEDICAL CENTER

صحة ... ابتسامة ... جمال
Health ... Smile ... Beauty

File No: ....

Date: 1 /6 /19

Date: 1/5/2019

File Number: 100249

Patient Name: Fatiha el Moufatkkir إسم المريض:

Date Of Birth (تاريخ الميلاد) : 14/8/86 Gender (الجنس) : M / (F) Marital Status: (الحالة الاجتماعية) ....

Nationality (الجنسية): Maroc Occupation (الوظيفة) : Hairdresser

Address (العنوان) : Al Wazka N: 43 Phone No. (رقم الهاتف): 0559739976

E-MAIL: .... How did you know about us: ....

Medical History التاريخ الطبي

Medical Condition الحالة الطبية	Yes/No نعم / لا	If 'YES' give details اذا كانت الاجابة نعم اذكر بالتفصيل
Recent or current drugs/Medical Treatment هل تتعاطى أي أدوية أو تتلقى اي علاجات حديثا؟	نعم	
Cortisteroids/Immunosuppressant هل تتعاطى أي ستروidات او مثبطات للمناعة؟	X	
Allergies هل لديك أي حساسية؟	X	
Surgical Operations, Serious Illness هل اجريت أي عمليات جراحية او تعاني من اي امراض؟	X	
Cardiac surgery, Rheumatic fever, Endocarditis, Artificial heart valve, Congenital heart disease جراحة قلب، حمى روماتويد، التهاب شغاف القلب، صمام قلب صناعي، امراض القلب	X	
High Blood Pressure, Bleeding disorders, Anticoagulants هل لديك ارتفاع في ضغط الدم، مشاكل في النزيف او تتعاطى أي مميعات للدم؟	X	
Anemia, Leukemia انيميا (فقر الدم)، لوكيميا (سرطان الدم)	نعم	
Chest disease, Asthma, Bronchitis, TB, Other امراض صدرية، ازمة تنفسية، التهاب في القصبات، السل، امراض اخرى	X	
Renal, Urinary, Sexually transmitted disease هل تعاني من اي امراض في الكلى او امراض بولية او تناسلية؟	X	
Pregnancy, Contraceptive pill, Menstrual problems هل انت حامل؟ هل تتعاطين اي مانع للحمل؟ هل تعانين من مشاكل في الدورة الشهرية؟	X	
Hepatitis, Jaundice, Other liver diseases التهاب الكبد الوبائي ، الصفراء، اي امراض كبدية اخرى	X	
Peptic ulcer, Crohn's ulcerative colitis, Other قرحة معوية، داء كرون، أي امراض معوية أخرى؟	X	
Epilepsy, or any other neurological disease هل تعاني من الصرع او اي امراض في الجهاز العصبي؟	X	
Thyroid Diseases, Diabetes هل تعاني من مرض السكري او امراض الغدة الدرقية؟	X	
Other conditions هل تعاني من أي أمراض أخرى؟ HSV, HIV...etc فيروس الايدز، فيروس الحلا البسيط	X	

مـركـز أوركـيـد الـطـبـي
ORCHID MEDICAL CENTER

صحة ... ابتسامة ... جمال
Health ... Smile ... Beauty

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 any procedures which are advisable in their professional judgment.

I understand that no warranty or guarantee has been made to me as a result or cure just as there may be risks and hazards in continuing my present condition without treatment.

I understand that there are also risks and hazards to the performance of the diagnostic and/or surgical procedures.
I realize that common surgical or diagnostic procedures are potential for an infection, swelling, bleeding, pain or allergic reaction.

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

I consent that all medical history and information I provided in my medical file is true and I understand that any information I provide regarding my medical status will be kept confidential and anonymous.

I believe that I have sufficient information to give this consent. I certify that this form has been fully explained to me and that I have read it and I understand its' content and I sign it with all my will.

I am fully aware that any payments is NON refundable

Patient's Signature/ Guardians (In case of minors):

Date: ... / ... / .....

نموذج اقرار طبي

أوافق و أسمح للطبيب بعلاج حالتي المرضية التي تم شرحها لي من قبل الطبيب المختص و المؤهل.

أتفهم أن بعض الإجراءات الطبية والتشخيصية الاضافية قد تكون ضرورية من أجل تزويدي بالعلاج الأمثل و الخدمة الافضل.

أتفهم أنه من الممكن أن يكتشف الطبيب خلال العلاج أمورا مختلفة عن ما ذكر في الفحص الأولي و التي قد تتطلب إجراءات إضافية أو مختلفة عن تلك المخطط لها.

أفوض الطبيب المعالج باتخاذ كل الاجراءات الطبية و العلاجات اللازمة و المطلوبة بحكم خبرته المهنية و العلمية.

اقر أنه لم يتم تقديم اي ضمانات او تامين لنتائج العلاجات و الاجراءات الطبية او التجميلية المقدمة لي، كما اتفهم الاخطار و المضاعفات النتاجة عن عدم استكمال علاج حالتي المرضية.

أتفهم تماما كافة الاخطار و المضاعفات التي قد تكون مصاحبة للفحوصات والاجراءات العلاجية و الجراحية.
و ادرك ان بعض الاجراءات التشخيصية و العلاجية و الجراحية قد تؤدي الى مضاعفات كالالتهاب أو التورم أو النزيف أو الألم أو الحساسية

أتفهم أن هناك رسوم بالحد الأدنى يجب علي دفعها مقابل الخدمة العلاجية و أن جميع الرسوم المطلوبة يجب ان تسدد بالكامل قبل الانتهاء من العلاج.

أقر أن كافة المعلومات الطبية و التاريخ الطبي الذي قدمته لدى فتحي للملف صحيحة. و اتفهم ان اي معلومات تتعلق بحالتي الصحية ستبقى سرية تماما ولا يمكن الاطلاع عليها دون موافقتي

أقر أن لدي المعلومات الكاملة لتقديم هذا الاقرار و ان هذا النموذج قد تم شرحه لي بالكامل و اني قد قرأت و فهمت جميع تفاصيله بالكامل و اني وقعت عليه بكامل ارادتي

انا على دراية تامة أن أي مدفوعات للمركز هي غير قابلة للاسترداد

توقيع المريض / ولي الأمر (لمن هم دون السن القانونية):

التاريخ: 19 / 5 / ..1..

Patient Assesment Form استمارة تقييم المريض

Vital Signs المؤشرات الحيوية

Weight (الوزن): Kg	Height (الطول): cm	Blood Type (فصيلة الدم) :
Pulse (النبض): ppm	Blood Pressure (ضغط الدم) : /	Blood Sugar (سكر الدم) :

Chief Complaint سبب زيارة المريض للعيادة

Disease History :التاريخ المرضي	
Allergies الحساسية	
Medications الأدوية	
Pregnancy الحمل	
Previous Surgeries, Hospitalization عمليات سابقة ، ادخال للمستشفى	

Smoking (التدخين) : Y / N   Alcohol (تعاطي الكحول) : Y / N   Drugs (تعاطي العقاقير): Y / N

General & Clinical Findings الملاحظات العامة و السريرية

Examination الفحص

Radiography الصور الشعاعية

Diagnosis التشخيص

File No: ....

Date: / /

Treatment Plan خطة العلاج

Doctor's Signature and Stamp

....

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

PATIENT NAME: **FILE NO#:**

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
1/6/2019	ACNE + Scars plan: Roaccutan Blood test (CBC - Glucose fasting - lipid profiler - liver function)	Cons = 200 + Blood test		
	د. وسام مروان الطباع Dr. Wesam Marwan Al-Tabbaa اخصائي جلدية Dermatology specialist MOH License No.: V826 :ترخيص رقم Orchid Medical Centre مركز اوركيد الطبي			
12/6/2019	W = 71.5 P: oratan 20mg (1x2) Nestral Moist u-sheild gel Blood test = Normal			
	د. وسام مروان الطباع Dr. Wesam Marwan Al Tabbaa اخصائي جلدية Dermatology specialist MOH License No.: V826 :ترخيص رقم Orchid Medical Centre مركز اوركيد الطبي			
20/7/2019	Blood test (CBC - lipid profile - liver profile - Kidney profile - Glucose Random)	Cons + Blood test		
24/7/2019	oratan 20mg (1x2) 1 month			
	د. وسام مروان الطباع Dr. Wesam Marwan Al Tabbaa اخصائي جلدية Dermatology specialist MOH License No.: V826 :ترخيص رقم Orchid Medical Centre مركز اوركيد الطبي			

مـركــز أوركـيــد الـطـبـي
ORCHID MEDICAL CENTER

PATIENT NAME: **FILE NO#:**

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
16/10/2019:	Roaccutane 20 mg (1 X 2) 1 month eczema on arms		cons = 200	

Dr. Wesam Marwan Al Tabbaa
Dermatology specialist
Orchid Medical Center

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	Fatiha,,,,El Moufakkir	**IDN:**	784198683025146	**Mother Name:**	
Name (Ar)	فاتحة,,,,المفكير	**Card Number:**	092771892	**Mother Name (Ar):**	
Title:		**Nationality:**	MAR	**Family ID:**	
Title(Ar):		**Nationality (Ar):**	المغرب		
Issue Date:	24/01/2019	**Sex:**	F	**Sponsor Type:**	06
Expiry Date:	17/01/2021	**Date of Birth:**	14/02/1986	**Sponsor Name:**	قرقني للشعر
Marital Status:	02	**Husband IDN:**		**Sponsor Number:**	00
Residency Type:	02	**Residency Number:**	20120162652415	**Residency Expiry:**	17/01/2021
ID Type:	IL	**Occupation:**	5141	**Occupation Field:**	00

Photo

Signature Image

مـركـــز أوركـــيــد الـــطـبــي
ORCHID MEDICAL CENTER

AED 903.00 **RECEIPT VOUCHER (No.REC-003895)** **Date:01-06-2019**

Receive from Mr./Mrs./M/s. **1002249 - FATIHA ELMOUFAKKIR - 971559739976**

The sum of Dhs. **Nine Hundred Three Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **903.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **01-06-2019**

Being **CONSULTATION + CBC + LIPID PROFILE + GLUCOSE (FBS) + FULL LIVER FUNCTION + VAT**

Made by **Hiba**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted

Confirmed by : **1002249 - FATIHA ELMOUFAKKIR - 971559739976**

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

DAR AL HIKMAH
Medical Laboratory
مختبر دار الحكمة الطبى

Laboratory Analysis Report

Name	: Fathiha Moufakkir	Clinic File No.	:
Sex	: Female	Lab File No.	: 1906-05095
Date Of Birth	: 33 Y	Lab. Case No.	: 51984
Referred By	: Orchid Medical Center	Clinic Name	: Orchid Medical Center
Receiving Date	: JUN-01-19 11:38 PM	Reporting Date	: JUN-02-19 12:34 AM
Insurance Company	:	Insurance No.	:
Indication	:		

HEMATOLOGY & COAGULATION

Complete Blood Count

Test	Result	Unit	Reference Range	Methodology
Haemoglobin	14.0	g/dL	11.5 - 15.0	
Haematocrit (Hct)	40.5	%	35.0 - 47.0	
Erythrocyte Count (RBC)	5.0	10^6/mm3	3.9 - 5.4	Automated cell counter
MCV	81	µm^3	75 - 95	
MCH	28	pg	27 - 31	
MCHC	35	g/dL	32 - 36	Automated cell counter
RDW	14.0	%	< 14	
Platelet Count	319	10^3/mm3	150 - 400	Automated cell counter
Leucocyte Count (WBC)	7.2	10^3/mm3	3.5 - 10.0	Automated cell counter
Differential Count				
Neutrophils	65	%	40 - 75	
Lymphocytes	27	%	20 - 45	
Monocytes	6	%	2 - 10	
Eosinophils	2	%	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

Mona

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

Final Report
Page 1 of 1

Printed by : Er-Fe Heart Balinait

Printed on : JUN-02-19 12:32 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

Laboratory Analysis Report

Name	:Fathiha Moufakkir	Clinic File No.	:
Sex	:Female	Lab File No.	: 1906-05095
Date Of Birth	:33 Y	Lab. Case No.	: 51984
Referred By	:Orchid Medical Center	Clinic Name	: Orchid Medical Center
Receiving Date	:JUN-01-19 11:38 PM	Reporting Date	: JUN-02-19 12:34 AM
Insurance Company	:	Insurance No.	:
Indication	:		

CLINICAL CHEMISTRY

Test	Result	Unit	Reference Range	Methodology
Glucose, Random	102.0	mg/dL	60.0 - 140.0 Non pregnant: 60 - 140 Pregnant: 60 - 105	
Sample Type				

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

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

Printed by : Er-Fe Heart Balinoit

Printed on : JUN-02-19 12:31 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

DAR AL HIKMAH Medical Laboratory
مختبر دار الحكمة الطبي

Laboratory Analysis Report

Name	:Fathiha Moufakkir	Clinic File No.	:
Sex	:Female	Lab File No.	: 1906-05095
Date Of Birth	:33 Y	Lab. Case No.	: 51984
Referred By	:Orchid Medical Center	Clinic Name	: Orchid Medical Center
Receiving Date	:JUN-12-19 08:30 PM	Reporting Date	: JUN-12-19 08:32 PM
Insurance Company	:	Insurance No.	:
Indication	:		

CLINICAL CHEMISTRY

Test	Result	Unit	Reference Range	Methodology
Glucose, Random	102.0	mg/dL	60.0 - 140.0 Non pregnant: 60 - 140 Pregnant: 60 - 105	
Sample Type				
Cholesterol	160.0	mg/dL	Desirable:<200 Borderline:200-240 High level:>240	Enzymatic
Triglycerides	72.4	mg/dL	Desirable:<150 Borderline:150-160 High level:>160	Enzymatic
HDL Cholesterol	46.1	mg/dL	42.0 - 88.0	
LDL Cholesterol	99.4	mg/dL	Optimal:<100 Borderline high:100-159 High:160-189	Gel Card Technique
VLDL Cholestrol	14.5	mg/dL	7.0 - 30.0	Calculation
Cholesterol/HDL	3.5	Ratio	< 4.5	Calculation
HDL/LDL	0.5	Ratio	> 0.3	Calculation
Sample Type *Serum*				
Alanine Aminotransferase (ALT)	22	U/L	< 34	Kinetic
Aspartate Aminotransferase (AST)	20	U/L	< 31	

* 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 : ...

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

Printed by : Er-Fe Heart Balinoit

Printed on : JUN-12-19 09:02 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

DAR AL HIKMAH
Medical Laboratory
مختبر دار الحكمة الطبى

Laboratory Analysis Report

Name	:**Fathiha Moufakkir**	Clinic File No.	:
Sex	:**Female**	Lab File No.	: **1906-05095**
Date Of Birth	:**33 Y**	Lab. Case No.	: **51984**
Referred By	:**Orchid Medical Center**	Clinic Name	: **Orchid Medical Center**
Receiving Date	:**JUN-12-19 08:30 PM**	Reporting Date	: **JUN-12-19 08:32 PM**
Insurance Company	:	Insurance No.	:
Indication	:		

CLINICAL CHEMISTRY

Test	Result	Unit	Reference Range	Methodology
Gamma Glutamyl Transferase (GGT)	19.9	U/L	< 38	
Bilirubin total	0.59	mg/dL	< 2.0	Diazo Reaction
Bilirubin direct	0.20	mg/dL	< 0.2	Colorimetric
Total Protein	6.4	g/dL	6.4 - 8.3	Colorimetric
Albumin	4.3	g/dL	3.5 - 5.2	Colorimetric
Globulin	2.1	g/dL	1.2 - 5.3	
Alkaline phosphatase (ALP)	87.0	U/L	<98	Colorimetric

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 : ...

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

Printed by : Er-Fe Heart Balinoit

Printed on : JUN-12-19 09:02 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

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 903.00 **RECEIPT VOUCHER (No.REC-004439)** **Date:20-07-2019**

Receive from Mr./Mrs./M/s. **1002249 - FATIHA ELMOUFAKKIR - 971559739976**

The sum of Dhs. **Nine Hundred Three Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **903.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **20-07-2019**

Being **CONSULTATION + CBC + LIPID PROFILE + GLUCOSE (FBS) + FULL LIVER FUNCTION + VAT**

Made by **Rana**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted

Confirmed by : **1002249 - FATIHA ELMOUFAKKIR - 971559739976**

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

Piercing Consent Form

Clinic Name; Fatiha Moefiakhr. (Patient name)

Clinic Address; Orchid Medical Centre. Sharjah. City: ______ Country: ______

Customers Name: ______

Date of Birth: 14/2/86 If under 24 months old, had their vaccination shots: Y N

Customer Address: Sharjah.

Mobile: 0559799976. E-mail: ______

Sterilization Lot Number [ ] Product Code: B5MED239YTN.

I hereby authorized to have my / my child / my grandchild ______ to be pierced, I have read and understand the following information which is very important in limiting or reducing post piercing problems during aftercare. By my signature below, I declare the following;

- I /He / She is not under the care of Medical Doctor/s for any medical condition or otherwise prohibiting from piercing procedure.
- I / He/ She do not suffer from Diabetes, Epilepsy, Hepatitis, HIV/AIDS, Hemophilia, Dizziness or any heart condition, further not under the influence or regular prescribe medication such as blood thinning medication.
- I am not under the influence of drugs or alcohol. I am not pregnant.
- I have been informed about the piercing procedure and given a copy of piercing after care Instructions, which I have read and understand. I understand that after piercing care procedure varies depending on whether the piercing is of the ear lobe / ear cartilage / nose or belly / naval. I have noted the differences.
- I understand that the possibility or infection may exist due to improper hygiene, metal sensitivity or other causes, however the most common is due to a failure to carefully follow to recommend After Care Procedure.
- I understand and accept that ear piercing in the ear cartilage may carry a greater possible risk of redness, swelling and infection due to the nature of piercing the area of the ear and I knowingly accept this risk.
- I understand that due to the nature of the piercing, exposure of newly pierced area to certain environments such as swimming and participation in athletic events (exercising) may increase the likelihood of infection.
- I will follow Piercing after Care Procedure.
- In case of belly/naval piercing, I am aware that my skin/ body may reject the foreign metal causing for piercing to close.
- I am over the age of ______ or consent on behalf of a minor, under the age of consent, that I am the parent or legal guardian of such minor understand that a minor signing as commits an act of fraud.

By signing this Piercing Consent Form, I hereby acknowledge that I understand the AFTERCARE procedure and the risk of infection. Knowing the risks, I consent to having my/ daughter / son ______ pierced by a medical professional of this clinic and as consideration for the clinic agreeing to pierce my or consent to pierce ______ and to the extent permissible by law I willfully assume all responsibility for injury or loss, of any kind, that may be associated with this piercing procedure. If signing as parent or legal guardian on behalf of a minor, I will hold myself liable and will indemnify the clinic and its staff/s, manufacturer, importers, distributor, promoters and will I further understand that making a false statement constitutes an act of fraud.

______ Date: ______
Customer/ Parent/ Legal guardian Signature (if customer is under the legal age, this must be signed by the parent or legal guardian)

______ Date: 25/7/14.
Medical Professional.

Signature back side

Clinic file copy, keep safe for customer records, attached products sterilization reference here.

EC Compliant
Sterilization Lot Number:
1716 APR26
LOMITA, CA 90717

OPEN Jet

Patient Details

Patient Name	Fatiha El Moufakkir
DOB	14-02-1986
Patient Id	784198683025146
Gender	Female

Prescription Detail

Facility	ORCHID MEDICAL CENTRE(7243)
Prescription Issue Date	24-Jul-2019 13:15:06
,escription Expiry Date	27-Jul-2019 13:15:06
Clinician Name	Wesam Marwan Altabbaa(MOHD54409)
Prescription No	3064946
Status	Active

Diagnosis Details

Primary

- Acne vulgaris L70.0

Prescribed Medication

- E08-3921-03188-02 Isotretinoin (Oratane® 20mg) 20mg Capsule 30's (15's Blister x 2)
  Qty:60 Capsule, **Duration:**30 days, **Strength:**20 mg, **Refill:**0
  Clinician Comment:AFTER MEAL
  Dosage Advice: Take 1 Capsule Twice a day

Given to Patient

DAR AL HIKMAH
Medical Laboratory
مختبر دار الحكمة الطبى

Laboratory Analysis Report

Name	:Fathiha Moufakkir	Clinic File No.	: 1002249
Sex	:Female	Lab File No.	: 1906-05095
Date Of Birth	:33 Y	Lab. Case No.	: 53848
Referred By	:Orchid Medical Center	Clinic Name	: Orchid Medical Center
Receiving Date	:JUL-20-19 01:20 PM	Reporting Date	: JUL-20-19 02:57 PM
Insurance Company	:	Insurance No.	:
Indication	:		

CLINICAL CHEMISTRY

Test	Result	Unit	Reference Range	Methodology
Glucose, Random	81.6	mg/dL	60.0 - 140.0 Non pregnant: 60 - 140 Pregnant: 60 - 105	
Sample Type				
Cholesterol	160.0	mg/dL	Desirable:<200 Borderline:200-240 High level:>240	Enzymatic
Triglycerides	60.4	mg/dL	Desirable:<150 Borderline:150-160 High level:>160	Enzymatic
HDL Cholesterol	64.0	mg/dL	42.0 - 88.0	
LDL Cholesterol	83.9	mg/dL	Optimal:<100 Borderline high:100-159 High:160-189	Gel Card Technique
VLDL Cholestrol	12.1	mg/dL	7.0 - 30.0	Calculation
Cholesterol/HDL	2.5	Ratio	< 4.5	Calculation
HDL/LDL	0.8	Ratio	> 0.3	Calculation
Sample Type *Serum*				
Alanine Aminotransferase (ALT)	11	U/L	< 34	Kinetic
Aspartate Aminotransferase (AST)	14	U/L	< 31	

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Analysed by : Ashar Al Rabie
Medical Laboratory Technologist
License No : T19042

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

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DAR AL HIKMAH
Medical Laboratory
مختبر دار الحكمة الطبى

Laboratory Analysis Report

Name	:Fathiha Moufakkir		Clinic File No.	: 1002249
Sex	:Female		Lab File No.	: 1906-05095
Date Of Birth	:33 Y		Lab. Case No.	: 53848
Referred By	:Orchid Medical Center		Clinic Name	: Orchid Medical Center
Receiving Date	:JUL-20-19 01:20 PM		Reporting Date	: JUL-20-19 02:57 PM
Insurance Company	:		Insurance No.	:
Indication	:			

CLINICAL CHEMISTRY

Test	Result		Unit	Reference Range	Methodology
Gamma Glutamyl Transferase (GGT)	36.0		U/L	< 38	
B...rubin total	0.61		mg/dL	< 2.0	Diazo Reaction
Bilirubin direct	0.30	H	mg/dL	< 0.2	Colorimetric
Total Protein	6.5		g/dL	6.4 - 8.3	Colorimetric
Albumin	4.0		g/dL	3.5 - 5.2	Colorimetric
Globulin	2.5		g/dL	1.2 - 5.3	
Alkaline phosphatase (ALP)	58.0		U/L	< 98.0	Colorimetric
Sample Type	*Serum*				

End of Report

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Analysed by : Ashar Al Rabie
Medical Laboratory Technologist
License No : T19042

Final Report
Page 2 of 2

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

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DAR AL HIKMAH
Medical Laboratory
مختبر دار الحكمة الطبى

Laboratory Analysis Report

Name	: Fathiha Moufakkir	Clinic File No.	: 1002249
Sex	: Female	Lab File No.	: 1906-05095
Date Of Birth	: 33 Y	Lab. Case No.	: 53848
Referred By	: Orchid Medical Center	Clinic Name	: Orchid Medical Center
Receiving Date	: JUL-20-19 01:20 PM	Reporting Date	: JUL-20-19 02:58 PM
Insurance Company	:	Insurance No.	:
Indication	:		

HEMATOLOGY & COAGULATION

Complete Blood Count

Test	Result	Unit	Reference Range	Methodology
Haemoglobin	13.8	g/dL	11.5 - 15.0	
Haematocrit (Hct)	41.9	%	35.0 - 47.0	
ythrocyte Count (RBC)	5.0	10^6/mm3	3.9 - 5.4	Automated cell counter
MCV	84	µm^3	75 - 95	
MCH	28	pg	27 - 31	
MCHC	33	g/dL	32 - 36	Automated cell counter
RDW	14.8	%	< 14	
Platelet Count	311	10^3/mm3	150 - 400	Automated cell counter
Leucocyte Count (WBC)	7.3	10^3/mm3	3.5 - 10.0	Automated cell counter
Differential Count				
Neutrophils	62	%	40 - 75	
Lymphocytes	30	%	20 - 45	
Monocytes	6	%	2 - 10	
Eosinophils	2	%	0 - 5	
Basophil	0	%	0 - 1	

Sample Type : EDTA BLOOD

End of Report

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Analysed by : Ashar Al Rabie
Medical Laboratory Technologist
License No : T19042

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

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DAR AL HIKMAH
Medical Laboratory
مختبر دار الحكمة الطبي

Laboratory Analysis Report

Name	: **Fathiha Moufakkir**	Clinic File No.	: **1002249**
Sex	: **Female**	Lab File No.	: **1906-05095**
Date Of Birth	: **33 Y**	Lab. Case No.	: **53848**
Referred By	: **Orchid Medical Center**	Clinic Name	: **Orchid Medical Center**
Receiving Date	: **JUL-20-19 01:20 PM**	Reporting Date	: **JUL-20-19 02:57 PM**
Insurance Company	:	Insurance No.	:
Indication	:		

CLINICAL CHEMISTRY

Test	Result	Unit	Reference Range	Methodology
Sodium	136.2	mmol/L	136.0 - 145.0	
Potassium (K)	4.3	mmol/L	3.5 - 5.5	
loride (Cl)	103.0	mmol/L	94.0 - 110.0	
Urea	22.2	mg/dL	< 55.0	
Creatinine	0.63	mg/dL	< 1.1	
Uric Acid	5.1	mg/dL	< 7.2	
Phosphorous	3.3	mg/dL	2.5 - 4.5	
Calcium	8.7	mg/dL	8.6 - 10.2	Colorimetric

Sample Type : Serum

End of Report

* Samples are processed on the same day of request unless indicated
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Analysed by : Ashar Al Rabie
Medical Laboratory Technologist
License No : T19042

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

Final Report
Page 1 of 1

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مـركـــز أوركـــيـــد الــطـبـــي
ORCHID MEDICAL CENTER

AED 105.00 **RECEIPT VOUCHER (No.REC-004476)** **Date:24-07-2019**

Receive from Mr./Mrs./M/s. **1002249 - FATIHA ELMOUFAKKIR - 971559739976**

The sum of Dhs. **One Hundred Five Dirhams and Zero Fils Only**

By Cash **105.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **24-07-2019**

Being **NOSE PIERCING + VAT**

Made by **Rana**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted

Confirmed by : **1002249 - FATIHA ELMOUFAKKIR - 971559739976**

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

Patient Details

Patient Name	Fatiha El Moufakkir
DOB	14-02-1986
Patient Id	784198683025146
Gender	Female

Prescription Detail

Facility	Bella Rose Medical Center llc(DHA/LS/2992011/47774)
Prescription Issue Date	07-Sep-2019 20:14:40
Prescription Expiry Date	10-Sep-2019 20:14:40
Clinician Name	Nadeem Ghreir(DHA-P-0068963)
Prescription No	4465086
Status	Active

Diagnosis Details

Primary

- Acne vulgaris L70.0

Prescribed Medication

- E08-3921-03188-02 Isotretinoin (Oratane® 20mg) 20mg Capsule 30's (15's Blister x 2)
  Qty:60 Capsule, **Duration:**30 days, **Strength:**20 mg, **Refill:**0
  Clinician Comment:after meal
  Dosage Advice: Take 2 Capsule Once a day

OPEN Jet

Patient Details

Patient Name	Fatiha El Moufakkir
DOB	14-02-1986
Patient Id	784198683025146
Gender	Female

Prescription Details

Facility	Bella Rose Medical Center llc(DHA/LS/2992011/47774)
Prescription Issue Date	16-Oct-2019 17:18:09
Prescription Expiry Date	19-Oct-2019 17:18:09
Clinician Name	Nadeem Ghreir(DHA-P-0068963)
Prescription No	5907946
Status	Active

Diagnosis Details

Primary
- Acne vulgaris L70.0

Prescribed Medication

- E74-4637-03188-01 Isotretinoin (Roaccutane ® 20mg) 20mg Capsule 30's (10's Blister x 3)
  Qty:60 Capsule, **Duration:**30 days, **Strength:**20 mg, **Refill:**0
  Clinician Comment:AFTER MEAL
  Dosage Advice: Take 1 Capsule Twice a day

مـركـــز أوركـــيـــد الـــطــبـــي
ORCHID MEDICAL CENTER

AED 210.00 **RECEIPT VOUCHER (No.REC-005551)** **Date:16-10-2019**

Receive from Mr./Mrs./M/s. **1002249 - FATIHA ELMOUFAKKIR - 971559739976**

The sum of Dhs. **Two Hundred Ten Dirhams and Zero Fils Only**

By Cash **210.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **16-10-2019**

Being **CONS + VAT**

Made by **Rana**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted

Confirmed by : **1002249 - FATIHA ELMOUFAKKIR - 971559739976**

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