مركز أوركيد الطبي
ORCHID MEDICAL CENTER

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

File No: .....

Date: 2 / 5 / 2020

Date: ... / ... / ..... File Number: 100 4465

Patient Name: Fatima Ibrahim Al Awadhi إسم المريض: .....

Date Of Birth (تاريخ الميلاد): 5/6/67 Gender (الجنس): M F Marital Status:(الحالة الاجتماعية) .....

Nationality (الجنسية): U.A.E Occupation (الوظيفة): .....

Address (العنوان): ..... Phone No. (رقم الهاتف): 050 481 0220

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؟	لا	
Cortisteroids/Immunosuppressant هل تتعاطى أي ستيرويدات او مثبطات للمناعة؟	لا	
Allergies هل لديك أي حساسية؟	لا	
Surgical Operations, Serious Illness هل اجريت أي عمليات جراحية او تعاني من اي امراض؟	نعم	تولسيزرين
Cardiac surgery, Rheumatic fever, Endocarditis, Artificial heart valve, Congenital heart disease جراحة قلب، حمى روماتويد، التهاب شغاف القلب، صمام قلب صناعي، امراض القلب	لا	
High Blood Pressure, Bleeding disorders, Anticoagulants هل لديك ارتفاع في ضغط الدم، مشاكل في النزيف او تتعاطى أي مميعات للدم؟	لا	
Anemia, Leukemia انيميا (فقر الدم)، لوكيميا (سرطان الدم)	لا	
Chest disease, Asthma, Bronchitis, TB, Other امراض صدرية، ازمة تنفسية، التهاب في القصبات، السل، امراض اخرى	لا	
Renal, Urinary, Sexually transmitted disease هل تعاني من اي امراض في الكلى او امراض بولية او تناسلية؟	لا	
Pregnancy, Contraceptive pill, Menstrual problems هل انت حامل؟ هل تتعاطين اي مانع للحمل؟ هل تعانين من مشاكل في الدورة الشهرية؟	لا	
Hepatitis, Jaundice, Other liver diseases التهاب الكبد الوبائي ، الصفراء، اي امراض كبدية اخرى	لا	
Peptic ulcer, Crohn's ulcerative colitis, Other قرحة معوية، داء كرون، أي امراض معوية أخرى؟	لا	
Epilepsy, or any other neurological disease هل تعاني من الصرع او اي امراض في الجهاز العصبي؟	لا	
Thyroid Diseases, Diabetes هل تعاني من مرض السكري او امراض الغدة الدرقية؟	لا	
Other conditions هل تعاني من أي أمراض أخرى؟ HSV, HIV...etc فيروس الايدز، فيروس الحلا البسيط	لا	

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Health ... Smile ... Beauty

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 تأمين لنتائج العلاجات و الاجراءات الطبية او التجميلية المقدمة لي، كما اتفهم الاخطار و المضاعفات الناتجة 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: 2 / 5 / 2020

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: ... / ... / .....

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
2/5/202	Blood test U.t profile			
	+ Lipid profile			
	+ + CBC			

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	Fatima,Ibrahim,Mohammed,Saleh,Alawadhi	**IDN:**	784196708190762	**Mother Name:**	
Name (Ar)	فاطمه,ابراهيم,محمد,صالح,العوضي	**Card Number:**	083942296	**Mother Name (Ar):**	
Title:		**Nationality:**	ARE	**Family ID:**	401005477
Title(Ar):		**Nationality (Ar):**	الإمارات العربية المتحدة		
Issue Date:	15/06/2017	**Sex:**	F	**Sponsor Type:**	
Expiry Date:	15/06/2022	**Date of Birth:**	05/06/1967	**Sponsor Name:**	
Marital Status:	02	**Husband IDN:**		**Sponsor Number:**	
Residency Type:		**Residency Number:**		**Residency Expiry:**	
ID Type:	ID	**Occupation:**	99	**Occupation Field:**	00

Photo

Signature Image

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 2,340.00 **RECEIPT VOUCHER (No.REC-008643)** **Date:02-05-2020**

Receive from Mr./Mrs./M/s. **1004465 - FATIMA ALAWADHI - 971504810220**

The sum of Dhs. **Two Thousand Three Hundred Forty Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **2,340.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **02-05-2020**

Being **diet plan + vat + lab test**

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 : **1004465 - FATIMA ALAWADHI - 971504810220**

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

Name	: . Fatima Al Awadhi	Clinic File No.	: 1004465
Sex	: Female	Lab File No.	: 2005-09532
Date Of Birth	: 52 Y	Lab. Case No.	: DAH1009752
Referred by	: Orchid Medical Center	Clinic Name	: Orchid Medical Center
Receiving Date	: 02/05/2020	Reporting Date	: 02/05/2020
Insurance Company		Insurance No.	
Indication	:		

BIOCHEMISTRY

Test	Result		Unit	Reference Range	Methodology
Creatinine	0.43		mg/dl	0.1 - 1.2	BIOCHEMICAL
Uric Acid	3.7		mg/dl	0 - 7.2	BIOCHEMICAL
Phosphoreus	3.59		mg/dl	2.5 - 4.5	BIOCHEMICAL
Iron	**45.9**	**L**	ug/dl	50 - 170	BIOCHEMICAL
Vitamin B12	487.3		pg/ml	197 - 866	RIA
Magnesium	**1.37**	**L**	mg/dl	1.6 - 2.6	BIOCHEMICAL
ZINC	95.2		µg/dL	72.6 - 127	
VITAMIN D, 25-OH (TOTAL)	**29.0**	**L**	ng/ml	Sufficiency : 30 - 100 Insufficiency : 20 - < 30 Deficiency : < 20 Toxicity : > 100	ICMA

Interpretation Notes :

25 – OH Vitamin D is the metabolite that should be measured in blood to determine the overall Vitamin D status because it is the major storage form of Vitamin D in the human body. 25 – OH Vitamin D Increases in Vitamin D intoxication. 25 – OH Vitamin D decreases in Rickets, Osteomalacia, Secondary osteoporosis, hyperparathyroidism, Malabsorption of Vitamin D (e. g., severe liver disease, cholestasis) & diseases that increase Vitamin D metabolism (e. g., tuberculosis, sarcoidosis, primary hyperparathyroidism)

Sample Type : SERUM

End of Report

The laboratory is ISO 15189:2012 accredited by EGAC under number 515002. The scope of accreditation is published on www.egac.gov.eg. EGAC is ILAC-MRA signatory.

* 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 : Ahmed Maklad
Medical Technologist
License No : T56154
Printed by: Er-Fe Heart Balingit

Verified by : Mona Mohamed Hagras
Clinical Pathologist
License No : D42240
Printed on: 03/05/2020 12:46

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

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Referred by	: Orchid Medical Center	**Clinic Name**	: Orchid Medical Center
Receiving Date	: 02/05/2020	**Reporting Date**	: 02/05/2020
Insurance Company		**Insurance No.**	
Indication	:		

BIOCHEMISTRY

Test	Result		Unit	Reference Range	Methodology
LIPID PROFILE I					
Cholesterol	362	H	mg/dl	Desirable:<200 Borderline:200-240 High level:>240	BIOCHEMICAL
Triglyceride	107.1		mg/dl	Desirable:<150 Borderline:150-160 High level:>160	BIOCHEMICAL
Cholesterol HDL	75.9		mg/dl	35 - 79.5	BIOCHEMICAL
Cholesterol LDL	264.68	H	mg/dl	Optimal:<100 Borderline high:100-159 High:160-189	BIOCHEMICAL
Cholesterol/HDL ratio	4.77	H		<4.5	BIOCHEMICAL
VLDL CHOLESTEROL	21.42		mg/dl	7 - 40	CALCULATED

Sample Type : SERUM

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Receiving Date	: 02/05/2020	Reporting Date	: 02/05/2020
Insurance Company		Insurance No.	
Indication	:		

HAEMATOLOGY

Test	Result		Unit	Reference Range	Methodology
Complete Blood Count (CBC)					
HAEMOGLOBIN	14.81		gms/dl	11.5 - 15	AUTOMATED CELL COUNTER
HEMATOCRIT-PCV	43.6		%	35 - 47	AUTOMATED
RED BLOOD COUNT - RBC	4.65		10^12/L	3.9 - 5.4	ELECTRICAL IMPEDENCE
MCV	93.7		fL	75 - 95	RBC HISTOGRAMS
MCH	31.8	H	pg	27 - 31	CALCULATED
MCHC	34		gm/dl	32 - 36	CALCULATED
RDW CV	14.6	H	%	<14	AUTOMATED CALCULATED
PLATELET COUNT	235		10^9/L	150 - 450	ELECTRICAL IMPEDENCE
TOTAL LEUCOCYTE COUNT / WBC	5.22		10^9/L	3.5 - 10	AUTOMATED CELL COUNTER
DIFFERENTIAL COUNT (DC)					FLOWCYTOMETRY BY LASER
NEUTROPHILS	62		%	40 - 75	
LYMPHOCYTES	25		%	20 - 45	
MONOCYTES	9		%	2 - 10	
EOSINOPHILS	4		%	0 - 5	
BASOPHILS	0		%	0 - 1	

Sample Type : WHOLE BLOOD

End of Report

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Referred by	: Orchid Medical Center	**Clinic Name**	: Orchid Medical Center
Receiving Date	: 02/05/2020	**Reporting Date**	: 02/05/2020
Insurance Company		**Insurance No.**	
Indication	:		

ENDOCRINOLOGY

Test	Result	Unit	Reference Range	Methodology
THYROID PROFILE I				
Tri-iodothyronine-Free (FT3)	3.5	pg/ml	2.47 - 3.9	ECLIA
Thyroxine-Free (FT4)	0.7	ng/dL	0.61 - 1.12	ECLIA
Thyroid Stimulating Hormone (TSH)	1.5	uIU/ml	0.34 - 5.6	CLIA

Sample Type : SERUM

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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 320.00 **RECEIPT VOUCHER (No.REC-008698)** **Date:05-05-2020**

Receive from Mr./Mrs./M/s. **1004465 - FATIMA ALAWADHI - 971504810220**

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

By Cash **0.00** / By Credit Card **320.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **05-05-2020**

Being **folic acid 170 + folic acid 150**

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 : **1004465 - FATIMA ALAWADHI - 971504810220**

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