Discharge fax 40504902

PROFORMA BILL

DEBTOR : PMCARE SDN BHD (P00001)

PATIENT
ADDRESS

TEL :
SEX : MALE
NRIC NO :

EMPLOYEE NO. :
AGE : 1

BILL DATE : 26/03/2018
PAGE NO. : PAGE 1 OF 1
REGISTRATION NO. : P370865
ACCOUNT NO. : A-P370865-1
ADMISSION DATE : 23/03/2018 02:06:28 AM
DISCHARGE DATE : 26/03/2018 03:24:30 PM
DOCTOR : DR MELANIE MAJAHAM
ROOM TYPE (ROOM) : SSG (W3 / DB33 / C7)
CREDIT TERM : 30 DAYS

DESCRIPTION	CHARGES (RM)	DISCOUNT (RM)	TAX (RM)	TOTAL BILL (RM)	OTHERS (RM)	BALANCE (RM)
ADMINISTRATION FEE	3.00		0.18			
CONSULTATION FEE	270.00					1,164.18
DAY/NIGHT VISIT	891.00					1,637.58
DISPOSABLES	473.40					
LABORATORY	275.60					2,751.28
MEDICINES	838.10					2,995.93
PROCEDURE	244.65					
PROCEDURE BY DOCTOR	65.00					3,860.93
ROOM	800.00			4,030.33		4,030.33
USE OF EQUIPMENT/INSTRUMENTS	169.40					

GRAND TOTAL (RM)	4,030.15	(0.00)	0.18	4,030.33	0.00	4,030.33

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Cheque should be crossed and made payable to "DAMAI SERVICE HOSPITAL (HQ) SDN. BHD."

This is a computer generated bill and no signature is required
Date Printed :26/03/2018 15:27:04 By : KARINA

PROFORMA BILL

DEBTOR : PMCARE SDN BHD (P00001)

PATIENT :
ADDRESS :

TEL :
SEX : MALE EMPLOYEE NO. :
NRIC NO : AGE : 1

BILL DATE : 26/03/2018
PAGE NO. : PAGE 1 OF 4
REGISTRATION NO. : P370865
ACCOUNT NO. : A-P370865-1
ADMISSION DATE : 23/03/2018 02:06:28 AM
DISCHARGE DATE : 26/03/2018 03:24:30 PM
DOCTOR : DR MELANIE MAJAHAM
ROOM TYPE (ROOM) : SSG (W3 / DB33 / C7)
CREDIT TERM : 30 DAYS

DESCRIPTION	CHARGES (RM)	DISCOUNT (RM)	TAX (RM)	TOTAL BILL (RM)	OTHERS (RM)	BALANCE (RM)
ADMINISTRATION FEE						
23/03/2018 ADMINISTRATION FEE	3.00		0.18			
CONSULTATION FEE						
23/03/2018 CONSULTATION FEE - DR MELANIE MAJAHAM	235.00					
23/03/2018 CONSULTATION FEE (M.O) - DR.MEERA CHANDRASEKHAR	35.00					
DAY/NIGHT VISIT						
23/03/2018 DAY/NIGHT VISIT - DR MELANIE MAJAHAM	105.00					378.18
24/03/2018 DAY/NIGHT VISIT - DR MELANIE MAJAHAM	157.00					
24/03/2018 DAY/NIGHT VISIT - DR MELANIE MAJAHAM	105.00					640.18
25/03/2018 DAY/NIGHT VISIT - DR MELANIE MAJAHAM	157.00					
25/03/2018 DAY/NIGHT VISIT - DR MELANIE MAJAHAM	157.00					954.18
26/03/2018 DAY/NIGHT VISIT - DR MELANIE MAJAHAM	105.00					
26/03/2018 DAY/NIGHT VISIT - DR MELANIE MAJAHAM	105.00					1,164.18
DISPOSABLES						
23/03/2018 ALCOHOL SWAB	3.60					
23/03/2018 ALCOHOL SWAB	1.80					
23/03/2018 BABY IV BOARD LARGE [1 1/2" X 5"] APM603	12.00					
23/03/2018 BD Q-SYTE EXTENSION SET [REF 385102]	10.00					
23/03/2018 BLOOD SPECIMEN MATERIAL USED	7.00					

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Date Printed :26/03/2018 15:27:16 By : KARINA

PROFORMA BILL

DEBTOR : PMCARE SDN BHD (P00001)

PATIENT :
ADDRESS :

TEL :
SEX :
NRIC NO :

BILL DATE : 26/03/2018

REGISTRATION NO. : P370865
ACCOUNT NO. : A-P370865-1
ADMISSION DATE : 23/03/2018 02:06:28 AM
DISCHARGE DATE : 26/03/2018 03:24:30 PM
DOCTOR : DR MELANIE MAJAHAM
ROOM TYPE (ROOM) : SSG (W3 / DB33 / C7)
CREDIT TERM : 30 DAYS

DESCRIPTION	CHARGES (RM)	DISCOUNT (RM)	TAX (RM)	TOTAL BILL (RM)	OTHERS (RM)	BALANCE (RM)
DISPOSABLES						
23/03/2018 DISP FACE MASK WITH EAR LOOP	4.20					
23/03/2018 EASY-FLO XTEND WHITE 20CM	20.00					
23/03/2018 GLOVE LATEX SZ M [POWDER FREE]	16.40					
23/03/2018 IV CANNULA 24G X 3/4" [INTROCAN- 4251300]	40.80					
23/03/2018 NEEDLE 18G X 1 1/2"	4.50					
23/03/2018 NEEDLE 21G X 1 1/2"	4.50					
23/03/2018 SYRINGES 10ML	21.00					
23/03/2018 SYRINGES 3ML	21.00					
23/03/2018 SYRINGES TUBERCULIN 1ML	7.00					
23/03/2018 TEGADERM SZ 5CM X 5.7CM [PAED] 2-WD-1682	6.00					
23/03/2018 THERMOMETER SHEATHS	5.50					1,349.48
24/03/2018 ALCOHOL SWAB	1.80					
24/03/2018 GLOVE LATEX SZ S/M/L [F/B]	28.00					
24/03/2018 IV DRIP SET [INTRAFIX AIR- 4021819]	35.80					
24/03/2018 IV PRECISION DRIP SET [PAED] TS*M270LA	80.00					
24/03/2018 NEEDLE 18G X 1 1/2"	4.50					
24/03/2018 NEEDLE 21G X 1 1/2"	4.50					
24/03/2018 SYRINGES 3ML	21.00					
24/03/2018 SYRINGES 5ML	21.00					
24/03/2018 THERMOMETER SHEATHS	4.40					1,550.48
25/03/2018 ALCOHOL SWAB	2.40					
25/03/2018 ID BAND ADULT [WHITE]	6.00					
25/03/2018 INCOPAD SZ 17" X 24"	5.20					
25/03/2018 NEEDLE 18G X 1 1/2"	6.00					
25/03/2018 NEEDLE 21G X 1 1/2"	6.00					
25/03/2018 SYRINGES 3ML	28.00					

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PROFORMA BILL

DEBTOR : PMCARE SDN BHD (P00001)

PATIENT : NUAR
ADDRESS :

TEL :
SEX :
NRIC NO :

BILL DATE : 26/03/2018
PAGE NO. : PAGE 3 OF 4
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DOCTOR : DR MELANIE MAJAHAM
ROOM TYPE (ROOM) : SSG (W3 / DB33 / C7)
CREDIT TERM : 30 DAYS

DESCRIPTION	CHARGES (RM)	DISCOUNT (RM)	TAX (RM)	TOTAL BILL (RM)	OTHERS (RM)	BALANCE (RM)
DISPOSABLES						
25/03/2018 SYRINGES 5ML	28.00					
25/03/2018 THERMOMETER SHEATHS	1.10					1,633.18
26/03/2018 THERMOMETER SHEATHS	4.40					1,637.58
LABORATORY						
23/03/2018 C-REACTIVE PROTIEN	66.00					
23/03/2018 FBC (FULL BLOOD COUNT)	41.60					
23/03/2018 LAB ON CALL CHARGES	55.00					
23/03/2018 LFT (LIVER FUNCTION TESTS)	56.50					
23/03/2018 RENAL PROFILE	56.50					
MEDICINES						
23/03/2018 ALOCLAIR PLUS SPRAY 15ML	37.70					
23/03/2018 CALAMINE LOTION 120ML	17.70					
23/03/2018 E-ZYME [LEFTOSE] SYRUP 90ML	16.20					
23/03/2018 NORMAL SALINE 0.45% 500ML	26.90					
23/03/2018 NORMAL SALINE FOR INJECTION 10ML	7.00					
23/03/2018 PROSPAN COUGH SYRUP 100ML	21.50					
23/03/2018 TAMIN [PARACETAMOL] 10MG/ML INJ	145.20					
23/03/2018 ZYRTEC 1MG/ML SOLN 75 ML	32.00					2,217.38
24/03/2018 GENGIGEL SPRAY 20ML	53.80					2,271.18
25/03/2018 AUGMENTIN 228/5ML SYRUP 70ML	46.20					
25/03/2018 CO- AMOXICLAV 1.2 G INJ	387.00					
25/03/2018 PANADOL 250MG SUSP 60ML	16.20					2,720.58
26/03/2018 AQUEOUS CREAM [PER OUNCE]	16.10					
26/03/2018 HYDROCORTISONE CREAM 15GM	14.60					2,751.28

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PATIENT
ADDRESS

TEL :
SEX :
NRIC NO :

PROFORMA BILL

BILL DATE : 26/03/2018
PAGE NO. : PAGE 4 OF 4
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CREDIT TERM : 30 DAYS

DESCRIPTION	CHARGES (RM)	DISCOUNT (RM)	TAX (RM)	TOTAL BILL (RM)	OTHERS (RM)	BALANCE (RM)
PROCEDURE						
23/03/2018 BLOOD SPECIMEN	8.50					
23/03/2018 BLOOD SPECIMEN	8.50					
23/03/2018 I.V. DRIP SETTING	30.25					
23/03/2018 INJECTION I/M I/V S/C	25.50					
23/03/2018 OBSERVATION	33.00					
23/03/2018 RECORDING INTAKE / OUTPUT	20.00					
24/03/2018 INJECTION I/M I/V S/C	25.50					2,877.03
24/03/2018 OBSERVATION	26.40					
25/03/2018 INJECTION I/M I/V S/C	34.00					2,928.93
25/03/2018 OBSERVATION	6.60					
26/03/2018 OBSERVATION	26.40					2,969.53
PROCEDURE BY DOCTOR						2,995.93
23/03/2018 PROCEDURE BY DOCTOR - DR.MEERA CHANDRASEKHAR	65.00					
ROOM						
23/03/2018 SINGLE DELUXE ROOM	200.00					
24/03/2018 SINGLE DELUXE ROOM	200.00					3,260.93
25/03/2018 SINGLE DELUXE ROOM	200.00					3,460.93
26/03/2018 SINGLE DELUXE ROOM	200.00					3,660.93
USE OF EQUIPMENT/INSTRUMENTS						3,860.93
23/03/2018 PULSE OXIMETER	60.50					
24/03/2018 PULSE OXIMETER	48.40					3,921.43
25/03/2018 PULSE OXIMETER	12.10					3,969.83
26/03/2018 PULSE OXIMETER	48.40					3,981.93
						4,030.33
GRAND TOTAL (RM)	**4,030.15**	**(0.00)**	**0.18**	**4,030.33**	**0.00**	**4,030.33**

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Date Printed :26/03/2018 15:27:16 By : KARINA

PMCARE SDN BHD (458443-P)
FORM MM201 (Part II)

PMCare

GL Serial No. : 18032303210369
Previous GL No. : 18032303210369

Treatment & Investigation

Please indicate (√) nature of treatment and Investigation	☑ Blood Test ☐ Dietary Counseling ☑ Medical ☐ Operation ☐ Physiotherapy ☐ X-ray ☐ Others, Please specify : _____
Medication dispensed	ALOCAIR SPRAY 7ml GENTAMICIN SPRAY 7ml AUGMENTIN 228 MG BD PCM SPRAY 2.5 ML TDS ZYRTEC 2.5ML BD PCM 165 MG PRN F. SYNT 1.5 ML TDS

Please state procedures, investigation and operations performed	Type of Operation/Procedure/ Investigation	Date Performed	Performed by
	Venepuncture	23/3/18	DR MBBCH

Referred Doctors & Specialty				
	Name of Doctor		Specialty	
	Name of Doctor		Specialty	
	Name of Doctor		Specialty	

Follow up Treatment

Follow-up necessary?	☐ No ☑ Yes	If Yes, to which specialist? (Please state reason)
Please indicate (√) if patient needs to be/was crossed referred?	☑ No ☐ Yes	

Attending Doctor

In the case of **DEATH**, please advise				
	Date	_____day_____month_____year	Cause of Death	
	Time	_____am/pm		

To the best of my knowledge, I hereby declare that all the information given above is true and accurate.

Signature of Attending Doctor

Dr. Melanie Majahar
Consultant Paediatrician
MBBS (UM) MRCPCH (UK)
(MMC: 43158)
Attending Doctor's Stamp

26/3/18
Date

FORM MM201 (Part I)

CRD	:		
GL Serial No.	:	18032303210369	
Previous GL Serial No.	:	18032303210369	
Date/Time of Issuance	:	23/03/2018 03:21:04.569	
Attention	:	DR MELANIE MAJAHAM	
To	:	DAMAI SERVICE HOSPITAL	

TRANSMISSION

Sp/Hosp. Fax No.	:	0340435399
Other Fax No.	:	0340434900
By Hand/Courier/Mail	:	
Visit Type	:	NOT APPLICABLE
Service Type	:	ADMISSION
Appointment Date	:	23/03/2018

GUARANTEE LETTER ("GL")

GL Validity Period:

i) **To be utilized until 05/04/2018**
ii) **For one (1) Inpatient admission not exceeding ten (10) days**

EXCEEDING the following limits stated in Item No. 2.

2. The abovenamed patient is entitled to:

A total limit of not more than	AS CHARGED
A daily Room & Board charges inclusive of Meals & Tax of not more than	4BR STANDARD
Intensive Care Unit	0.00
Surgical fees of not more than	0.00
Anesthetic fees of not more than	0.00
Hospital Ancillary Services of not more than	0.00
A daily In–Hospital Physician Visit of not more than	0.00
Delivery Limit of not more than	N/A

3. Diagnosis (Provisional or Primary)

VIRAL INFECTION, UNSPECIFIED [HFMD]

4. Kindly note that:
   a. Expense entitlement is only for or directly related to medical/surgical condition referred to the Diagnosis as per above Item No. 3.
   b. Maternity Benefits coverage does not include expenses incurred for newborn beyond prenatal period.
   c. PMCare will not pay or be responsible for any expenses in excess of the above entitlement or incurred for non-entitlement as indicated above. The excess amount must be recovered by the hospital from the patient upon their discharge, to be advised in our Discharge Advice.
   d. Payment of claim is subject to timely submission of complete documents, i.e. within thirty (30) days from date of service or discharge.
   e. For extension of admission, the hospital must contact PMCare.
5. Kindly fax to our Careline Centre your final itemized bill, with diagnosis and surgical procedures done, so that we can advise you better on the actual coverage, bills and payment.
6. Please attach the completed form **MM201 (Part I & II)** together with your invoice for payment.
7. Please note that the following non-medical items are under exclusion:
   Congenital Anomalies; Birth Control & Infertility investigation or treatment; Sexually Transmitted Disease; A.I.D.S; Cosmetic Surgery; Psychiatric
   Disorder; and Dental Care. For complete listing, please refer to the Working Guidelines.

Yours faithfully,

For and on behalf of
PMCare Sdn Bhd

.....
Authorised Signatory

I, the abovenamed and/or on behalf of my dependent hereby consent to the processing.

PMCARE SDN BHD (458443-P)
FORM MM201 (Part II)

GL Serial No. : 18032303210369
GL No. : 18032303210369

Patient Name		Time	_____ am/pm
NRIC No.		Time	_____ am/pm
Membership N			
Service Type			

Primary Diagnosis

Primary diagnosis	VIRAL INFECTION, UNSPECIFIED [HFMD]
	ICD10 coding, if available
Etiology of the above diagnosis	VIRAL.
Presenting symptoms at time of admission	FEVER, COUGH, RN ORAL ULCERS, BLISTERS (VESICULAR RASH)
When was the date patient sought your consultation for this condition?	23 day 3 month 2018 year
To your knowledge, was the patient previously treated for this condition?	☐ No ☐ Yes When? _____ day _____ month _____ year Name/Address & contact number : -
In your professional opinion, when did the condition first develop?	20 day 03 month 2018. year
Any possibility of relapse?	☐ No ☐ Yes

Please indicate (√) if the illness/injury or treatment is/are

Motor vehicle accident related	☑ No	☐ Yes	Date of accident	_____ day _____ month _____ year
			Time of accident	_____ am/pm
Chronic	☑ No	☐ Yes	Cosmetic	☑ No ☐ Yes
Pregnancy related	☑ No	☐ Yes	Fertility related	☑ No ☐ Yes
Work related	☑ No	☐ Yes	Congenital	☑ No ☐ Yes
Psychological related	☑ No	☐ Yes		

Secondary Diagnosis

Diagnosis other than primary	—

Has patient suffered from/Is patient suffering any illnesses stated as follows:

Hypertension	☑ No	☐ Yes	Since?	_____ day _____ month _____ year
Cardiovascular Disease	☑ No	☐ Yes	Since?	_____ day _____ month _____ year
Gastrointestinal Disease	☑ No	☐ Yes	Since?	_____ day _____ month _____ year
Malignancy of any kind	☑ No	☐ Yes	Since?	_____ day _____ month _____ year
Diabetes	☑ No	☐ Yes	Since?	_____ day _____ month _____ year
Others	☑ No	☐ Yes	Since?	If yes, please specify _____ _____ day _____ month _____ year

PMCare Pre-Admission Form

Important Note : To request a Guarantee Letter, please complete this form prior to admission and email/fax to gl@pmcare.com.my/03 8023 9999.

Hospital Name	Damai Service Hospital (HQ)				
Contact Person		Contact No.	034043900	Fax	03-40434611
Admission Date	23 day 03 month 2018 year	Admission Time	10 (a)m/pm		
Patient Name					
PMCare Member ID					
Company Name					
Patient IC No./Birth Certificate					

Presenting symptoms at time of admission and physical finding	fever x 3/7 +generalised body rash x 3/7 +mouth ulcer x 1/7	Blood Pressure	
		Pulse	
		Respiratory rate	
		Temperature	36.8°C
Is this the **FIRST TIME** patient has this/these or similar symptom(s)?	☑ Yes ☐ No		
If no, how long has the condition existed?	____ year(s) ____ month(s) ____ week(s) ____ day(s)		
When did patient first consult you for this complaint/condition?	23 day 03 month 2018 year		
Provisional Diagnosis	Hand foot Mouth Disease		
Etiology of the above diagnosis	coxsackie virus ; enterovirus		

Please indicate (√) if the illness/injury or treatment is/are	Motor vehicle accident related	☑ No ☐ Yes	Date of accident	N/A day month year
	Slips, Trips or Fall	☑ No ☐ Yes		
	Accident at Work	☑ No ☐ Yes	Time of accident	N/A am/pm
	Cosmetic/Dental Care/Refractive error			☑ No ☐ Yes
	Chronic Illnesses			☑ No ☐ Yes
	Influence of Drugs/Alcohol			☑ No ☐ Yes
	Psychological Disorder/Psychiatric/Sleeping Disorder			☑ No ☐ Yes
	Pregnancy Related /infertility			☑ No ☐ Yes
	Self-Inflicted injuries/Violation of laws/Strike/Riots			☑ No ☐ Yes
	Congenital			☑ No ☐ Yes
	STD/HIV/AIDS			☑ No ☐ Yes

Has patient suffered from/Is patient suffering any illnesses stated as follows:	Hypertension, Diabetes	☑ No ☐ Yes	Since?	day month year
	Cardiovascular Disease	☑ No ☐ Yes	Since?	day month year
	Malignancy of any kind	☑ No ☐ Yes	Since?	day month year
	Stones of the Urinary system	☑ No ☐ Yes	Since?	day month year
	ENT conditions	☑ No ☐ Yes	Since?	day month year
	Hernias, haemorrhoids	☑ No ☐ Yes	Since?	day month year
	Endometriosis	☑ No ☐ Yes	Since?	day month year
	Others	☑ No ☐ Yes	Since?	(If yes, please specify) day month year

Can this condition be managed under outpatient basis?	☐ Yes ☑ No (If no, please state reason)	Reason	need IV fluids
Admission requires	☑ Hospitalisation ☐ Day Care ☐ On patient's request	Estimated length of stay	3 day
Please state **TREATMENT PLAN.** e.g. lab test, imaging, and etc	☑ Medication ☐ Procedure ☐ Surgery ☐ Physiotherapy ☐ Diagnostic Imaging ☑ Laboratory Test ☐ Others, Please specify :		**Estimated total cost** RM 5K
Signature and stamp of Admitting Physician/Surgeon	Dr. Melanie Majanam Consultant Paediatrician MBBS (UM) MRCPCH (UK) (MMC: 43158)		
If Admitting Doctor is a Medical Officer, please state Name and Specialty / Doctor to be referred to	DR. MELANIE (PAED) REFER TO DR. MELANIE (PAEDIATRICIAN)		

DAMAI SERVICE HOSPITAL (HQ) SDN. BHD.
109-119(1st Mile),
Jalan Sultan Azlan Shah (Jalan Ipoh)
51200 Kuala Lumpur,
Tel: 03-40434900 Fax: 03-40434611

GRIBBLES PATHOLOGY
(MALAYSIA) SDN BHD
149031-W

2nd Floor, Wisma Tecna
18A, Jalan 51A/223
46100 Petaling Jaya
Selangor Darul Ehsan
Malaysia

CARELINE 1300 88 0234
FAX +603 7957 7732
URL www.gribbles.com.my

Courier Run: KL2

Patient Details

Doctor Details
DR MELANIE MAJAHAM
DAMAI SERVICE HOSPITAL
115 JALAN IPOH

KUALA LUMPUR 51200

Lab No. : 18-1179997

SPECIAL CHEMISTRY — **SPECIMEN: WHOLE BLOOD**

PROTEIN STUDIES

*** C-Reactive Protein screen	35.7 mg/L	(< 11.0)

Validated by N.Mohanaraja B. BioMedical Sc.(Hons) UM,Dip MLT (USM).

HAEMATOLOGY — **SPECIMEN: WHOLE BLOOD**

Haemoglobin		121 g/L	(105-140)
RBC		4.69 x 10^{12}/L	(3.80-5.00)
PCV		0.36 L/L	(0.30-0.42)
MCV		77 fL	(73-90)
MCH		26 pg	(24-34)
MCHC		335 g/L	(300-360)
RDW		13.7 %	(11.0-15.0)
White Cell Count		8.1 x 10^9/L	(5.0-15.0)
Neutrophils	42 %	3.4 x 10^9/L	(1.5-8.0)
Lymphocytes	40 %	3.2 x 10^9/L	(2.5-8.0)
Monocytes	14 %	1.1 x 10^9/L	(< 1.2)
Eosinophils	4 %	0.3 x 10^9/L	(< 0.7)
Platelets		260 x 10^9/L	(150-400)

Validated by Siti Sazeelah Ahmad B.Sc MLT(UITM)

CC Drs: MELANIE MAJAHAM.

COMPUTER GENERATED REPORT - NO SIGNATURE REQUIRED

Printed On: 23/03/18 At: 09:00 Run#: 9589 Page#: 3

GRIBBLES PATHOLOGY
(MALAYSIA) SDN BHD
149031-W

2nd Floor, Wisma Tecna
18A, Jalan 51A/223
46100 Petaling Jaya
Selangor Darul Ehsan
Malaysia

CARELINE 1300 88 0234
FAX +603 7957 7732
URL www.gribbles.com.my

Courier Run: KL2

Doctor Details
DR MELANIE MAJAHAM
DAMAI SERVICE HOSPITAL
115 JALAN IPOH

KUALA LUMPUR 51200

pk

Lab No. : 18-1179997

BIOCHEMISTRY **SPECIMEN: SERUM**

Total Protein	72	g/L	(55-74)
Albumin	40	g/L	(33-47)
Globulin	32	g/L	(20-39)
Albumin/Globulin ratio	1.2		(1.0-2.5)
Alkaline Phosphatase	230	U/L	(70-320)
Total Bilirubin	6	umol/L	(< 21)
GGT	8	U/L	(< 51)
AST	35	U/L	(15-60)
ALT	17	U/L	(< 51)

RENAL PROFILE

* Sodium	137	mmol/L	(139-146)
Potassium	4.7	mmol/L	(3.5-5.1)
Chloride	102	mmol/L	(95-110)
Urea	3.6	mmol/L	(2.0-7.5)
Creatinine	23	umol/L	(20-60)
Uric Acid	0.30	mmol/L	(0.13-0.39)
Calcium	2.45	mmol/L	(2.10-2.55)
Corrected Calcium	2.45	mmol/L	(2.10-2.55)
Phosphate	1.76	mmol/L	(1.30-2.30)
Albumin	40	g/L	(33-47)

REPORT COMPLETED **PLEASE FILE**

Tests Requested:
CRP (SELEXON), HAEMATOLOGY GENERAL, MULTIPLE BIOCHEM ANALYSIS, RENAL PROFILE

CC Drs: MELANIE MAJAHAM.

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