PRESCRIPTION /ADVICE FORM

Ref No (IMPORTANT: Please copy from the Consultation Form)

PATIENT NAME Tariq Saboor

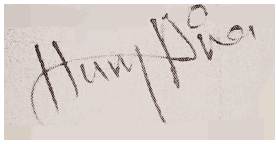
DIAGNOSIS Allergy, unspecified, sequela, Pruritus, unspecified, Weakness, Acute upper respiratory infection, unspecified

NATURE OF TREATMENT : (Please use separate sheet for each group)

☐ Pharmacy ☐ Diagnostic ☐ Physiotherapy ☐ Others

Item	Quantity
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	7
(FLUCONAZOLE : 150 MG) CAPSULES	5
(VITAMIN D (AS CHOLECALCIFEROL) : 5 MCG) (VITAMIN B12 : 2.4 MCG) (BETA CAROTENE : 1740 MCG) (MOLYBDENUM : 23 MCG) (VITAMIN C (ASCORBIC ACID) : 45 MG) (IODINE : 33 MCG) (IRON : 3.5 MG) (THIAMINE : 1.2 MG) (ZINC : 7 MG) (SELENIUM : 20 MCG) (MANGANESE : 1.8 MG) (MAGNESIUM : 120 MG) (BIOTIN : 30 MCG) (RIBOFLAVIN : 1.3 MG) (FOLIC ACID : 200 MCG) (CALCIUM : 250 MG) (VITAMIN K1 : 30 MCG) (CHROMIUM : 25 MCG) (COPPER : 0.45 MG) (PANTOTHENIC ACID : 5 MG) (VITAMIN B6 : 1.3 MG) (VITAMIN E : 4.5 MG) (NIACIN	30
(TERBINAFINE (AS HCL) : 1%) CREAM	3

Doctor's Signature and Stamp



Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

FOR PROVIDERS USE

CARD NO	2429-AE4C-DCD9-1DEA	AMOUNT CLAIMED	
PAYER	National Life And General Insurance	DATE	07-05-2024
NAME	Humaira	Signature and Stamp:	

I hereby certify having received prescribed treatment and allow NAS authorized personnel to obtain any requisite medical details from my current and previous physicians and/or case files.

BENEFICIARYS' SIGNATURE