1.HealthNet Policy Number: I038-000-115298135-01

2. Authorization Code:

2.Patient Name: IKECHUKWU VICTOR NDUCHE

3.Patient Date of Birth & Sex: 13-09-85(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0555891985

5.Nature of illness or Injury ☐ Acute ☐ Chronic ☐ Emergency

6.Are You the patient's primary physician ☐ Yes ☐ No

7.Presenting Complaints:

CO Highly pruritic swelling distributed all over the body 1day

: rashes began after he consumed some rice meal.

he has no previous history of allergies.

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiAllergic urticaria, Other pruritus, Essential (primary) hypertension

ICD Code L50.0, L29.8, I10

12.Etiology:

13.In case of Injury:mode of Injury/place of Injury

14.Plan / Details of Management

a.ProcedureFree follow-up consultation of the same diagnosis within 7 days of initial consultation by a General Practitioner.,CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,Intramuscular injection,Administered intravenously,Blood Count Complete Auto&Auto Difrntl Wbc Count

CPT code9.1,0005-111805-1021,0125-122107-1022,96372,96365,85025

b.Laboratiry Test:

c.Radiology / Investigations:

15.In Case of Hospitalization: Date of Addmission: Date of Discharge:

16.

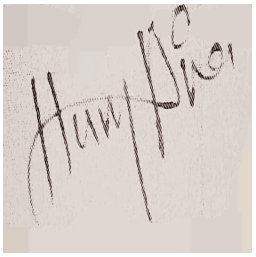
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0977-137204-0571	(CALAMINE : 15% W/V) (ZINC OXIDE : 5% W/V) LOTION	LOTION (200ML, GLASS BOTTLE)	1	Take 1Lotion 1Time(s) perDay For 1 Day(s) others

Date: 05-06-24(dd/mm/yy)

Doctor's Name Humaira

Signature and Stamp



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

Physician Code DHA-P-54155530 HNM Code

Authorization

I hereby authorize the Physician, Hospital or Pharmacy to file a claim for medical services on my behalf and I confirm that the above mentioned examination / investigation / therapy is given to me by the doctor. I hereby authorize any Hospital, Physician, Pharmacy or any other person who has provided medical services to me or my dependents to furnish NGI with any and all information with regard to any medical history, medical condition or medical services and copies of all medical and hospital records.

A Photocopy or teletax copy of this authorization shall be considered effective any valid as the original

Date: 05-06-24(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

NATIONAL GENERAL INSURANCE CO. (P.J.S.C)

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HealthNet