1.HealthNet Policy Number: I038-000-117253227-01 2. Authorization Code:

2.Patient Name: IHSSANE YAALA

3.Patient Date of Birth & Sex: 07-11-98(dd/mm/yy) ☐ Male ☑ Female

Mobile No.0501543860

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

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

7.Presenting Complaints:

C/o: Severe sorethroat. severe pain on swallowing./

Duration: 2days.

Already on antibiotics.

Conselled to continue current antibiotics.

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiAcute tonsillitis, unspecified, Pain in throat, Fever, unspecified ICD Code J03.90, R07.0, R50.9

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureCLOFEN ,DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,Intramuscular injection,9.019.01 - (9.01) - Follow Up - Consultation GP - (AED 0.0000) CPT code0005-149902-1021,0125-122107-1022,96372,9.01

b.Laboratiry Test:

c.Radiology / Investigations:

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

16.

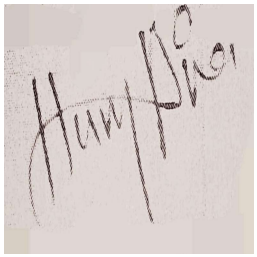
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
4874-125821-3801	(POVIDONE IODINE : 0.45%) SPRAY SOLUTION	SPRAY SOLUTION (50ML, BOTTLE)	5	Take 1Spray 4 Time(s) per Day For 5 Day(s) others
2027-560101-0392	(IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (16S, BLISTER)	4	Take 2Tablets 2 Time(s) per Day For 4 Day(s) after meal
0252-185801-0391	(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	10	Take 1Tablets 2 Time(s) per Day For 10 Day(s) after meal

Date: 12-08-24(dd/mm/yy)

Doctor's Name Humaira

Signature and Stamp



Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE 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: 12-08-24(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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

NGI House Building, P.O. Box 154, Deira, Dubai, Tel: +971 4 211 5800, Fax: +971 4 250 2854, Email: ngico@emirates.net.ae, Website: www.ngi.ae

HealthNet