1.HealthNet Policy Number I038-000-121378268-01 2. Authorization Code:

2.Patient Name RAHUL MAHMUD SABBIR

3.Patient Date of Birth & Sex 04-08-02(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0528639960

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

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

7.Presenting Complaints:

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiNonspecific urethritis, Other mucopurulent conjunctivitis, bilateral, Painful micturition, unspecified ICD Code N34.1, H10.023, R30.9

12.Etiology:

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

14.Plan / Details of Management

a.Procedure(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,Administered intravenously,9.019.01 - (9.01) - Follow Up - Consultation GP - (AED 0.0000) CPT code0005-107704-0801,96365,9.01

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
0005-119805-1172	(PREDNISOLONE : 5 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	Take 2Tablets 1Time(s) perDay For 5 Day(s) evening
0031-103204-0371	(CIPROFLOXACIN : 0.3%) EYE DROPS	EYE DROPS (5ML, DROPPER BOTTLE)	5	Take 2Drops 4 Time(s) per Day For 5 Day(s) others
0097-127405-0391	(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (3S, BLISTER)	1	Take 2Tablets 1Time(s) perDay For 1 Day(s) after meal

Date: 13-10-24(dd/mm/yy)

Doctor's Name Enomen Goodluck

Signature and Stamp

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Physician Code DHA-P-28040827 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: 13-10-24(dd/mm/yy) Signature of Insued / Claimint

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