1.HealthNet Policy Number I038-000-115298166-01 2. Authorization Code:

2.Patient Name ZAKARIA ABDELHAI

3.Patient Date of Birth & Sex 11-03-94(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0501989306

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

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

7.Presenting Complaints:

PC: Pain on passing urine, pain in the perinium and pain in the groin.

Also pain in the prostate.

Exam: GUS is essentially normal. No visible or palpable cough impulse.

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiAcute prostatitis, Calculus of kidney with calculus of ureter, Pain, unspecified ICD Code N41.0, N20.2, R52

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureBlood Count Complete Auto&Auto Difrntl Wbc Count,C-Reactive Protein,Urnls Dip Stick/Tablet Reagent Auto Microscopy,Gp Consultation CPT code85025,86140,81001,9

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
5098-116604-1171	(METRONIDAZOLE : 500 MG) TABLETS	TABLETS (20S, BLISTER)	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal
0042-136501-1173	(HYOSCINE : 10 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal
2027-560101-0392	(IBUPROFEN : 150 MG (PARACETAMOL : 500 MG FILM COATED TABLETS	FILM COATED TABLETS (16S, BLISTER	4	Take 2Tablets 3 Time(s) per Day For 4 Day(s) after meal
1161-274301-0392	(LEVOFLOXACIN (AS HEMIHYDRATE) : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (7S, BLISTER PACK)	7	Take 1Tablets 1Time(s) perDay For 7 Day(s) after meal

Date: 15-11-24(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: 15-11-24(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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HealthNet