1.HealthNet Policy Number I038-000-112964322-01 2. Authorization Code:

2.Patient Name ISAIAH JERONE PESCADOR ELIZARIO

3.Patient Date of Birth & Sex 12-09-15(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0522363835

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

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

7.Presenting Complaints:

PC: Fever, cough and pain in throat.

Cough is productive of clear phlegm and nostrils has thick purulent effluent.

Duration: 2days.

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiAcute tonsillitis, unspecified, Acute frontal sinusitis, unspecified, Allergic rhinitis, unspecified ICD Code J03.90, J01.10, J30.9

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureGp Consultation CPT code9

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
0005-106601-1171	(PARACETAMOL : 500 MG TABLETS	TABLETS (20S, BLISTER PACK	5	Take 1Tablets 3 Time(s) per Day For 5 Day(s) after meal
0097-127402-0391	(AZITHROMYCIN : 250 MG) FILM COATED TABLETS	FILM COATED TABLETS (6S, BLISTER)	6	Take 1Tablets 1 Time(s) per Day For 6 Day(s) after meal
0252-389902-1171	(LORATADINE : 5 MG) (PSEUDOEPHEDRINE SULPHATE : 120 MG) TABLETS	TABLETS (14S, BLISTER PACK)	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal
1516-107904-1111	(IBUPROFEN : 100 MG/5ML) SUSPENSION	SUSPENSION (110ML, BOTTLE)	5	Take 10ML 3 Time(s) per Day For 5 Day(s) after meal

Date: 04-12-24(dd/mm/yy)

Signature and Stamp

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

Doctor's Name Enomen Goodluck

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: 04-12-24(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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HealthNet