1.HealthNet Policy Number I038-000-120684878-01 2. Authorization Code:

2.Patient Name THAWDAR CHAN MYAE

3.Patient Date of Birth & Sex 08-04-99(dd/mm/yy) ☐ Male ☑ Female

Mobile No.0557745586

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

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

7.Presenting Complaints:

co fever on and off cough nasal blockage 24th dec. 2024

oe chest is congested no added sounds

restless

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiAcute upper respiratory infection, unspecified, Allergic rhinitis, unspecified, Cough, Fever, unspecified, Acute gastritis without bleeding

ICD Code J06.9, J30.9, R05, R50.9, K29.00

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureCEFTRIAXONE-TABUK IV,CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,Administered intravenously,Intramuscular injection,Blood Count Complete Auto&Auto Difrntl Wbc Count,C-Reactive Protein,nebulization with ventoline solution,9.019.01 - (9.01) - Follow Up - Consultation GP - (AED 0.0000)

CPT code0195-107704-0801,0005-149902-1021,0188-135906-2441,96365,96372,85025,86140,94640,9.01

b.Laboratiry Test:

c.Radiology / Investigations:

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

16.

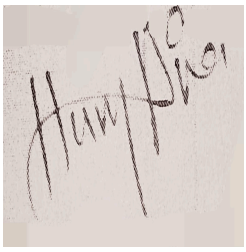
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0005-116702-2481	(DIPHENHYDRAMINE : 12.5 MG/5ML SYRUP (SUGAR FREE	SYRUP (SUGAR FREE (120ML, BOTTLE	1	Take 10 ml 3 times in a day

Date: 28-12-24(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: 28-12-24(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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

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