1.HealthNet Policy Number I038-000-117635838-01 2. Authorization Code:

2.Patient Name LOIQ YOROV

3.Patient Date of Birth & Sex 24-05-01(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0503542101

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

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

7.Presenting Complaints:

rash on body started on legs then progressed to whole body for 4 days

no history of drug ,medication ,

not allergic to any food

sore throat ,bodyache

no other medical condition

o\e macular rash red in color ,diffused , all over body

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiOther allergy, initial encounter ICD Code T78.49XA

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureOffice consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patients and/or familys needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family. CPT code9

b.Laboratiry Test:

c.Radiology / Investigations:

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

16.

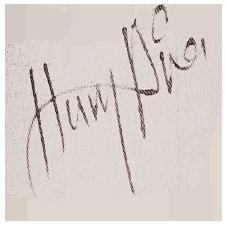
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
2594-627701-1171	(VITAMIN D3 : 400 IU) (MAGNESIUM : 48 MG) (ZINC : 3.4 MG) (VITAMIN K2 : 90 MCG) (CALCIUM : 320 MG) TABLETS	TABLETS (60S, BLISTER)	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) after meal
0397-116207-0391	(AMOXICILLIN : 500 MG (CLAVULANIC ACID : 125 MG FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) after meal
H21-2270-04687-06	(DEXTROSE : 50 MG/ML) (DEXTRAN 40 : 100 MG/ML) SOLUTION FOR INFUSION	Tablets	7	Take 1Tablets 1Time(s) perDay For 7 Day(s) after meal
0195-123701-0391	(CETIRIZINE HCL : 10 MG FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) evening

Date: 29-12-24(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: 29-12-24(dd/mm/yy) Signature of Insued / Claimint

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HealthNet