



1.HealthNet Policy Number

I038-000-  
115298065-01

2.  
Authorization  
Code:

2.Patient Name

KRISHNA GURUNG

3.Patient Date of Birth & Sex

26-05-87(dd/mm/yy)

☒ Male ☐  
Female

Mobile No.971585267967

5.Nature of illness or Injury

☐ Acute ☐ Chronic ☐ Emergency

6.Are You the patient's primary physician

☐ Yes ☐ No

7.Presenting Complaints:

co fever dry cough running nose 30th dec. 2024

oe

chest is congested no added sounds

restless

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevant Past Medical/Surgical History

Diagnosis Acute 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.Procedure Blood Count Complete Auto&Auto Diffrntl Wbc Count,C-Reactive Protein,Cul Bact Xcpt Urine Blood/Stool Aerobic Isol,PARAFUSIV I.V. 10MG/ML- (PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,CEFTRIAZONE-TABUK IV,CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,Administered intravenously,Intramuscular injection,Office 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 families 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 code 85025,86140,87070,2190-106618-1001,0195-107704-0801,0005-149902-1021,0188-135906-2441,96365,96372,9

b.Laboratory Test:

c.Radiology / Investigations:

15.In Case of Hospitalization: Date of Admission:

Date of Discharge:

16.

PRESCRIPTION WITH DOSAGE & DURATION

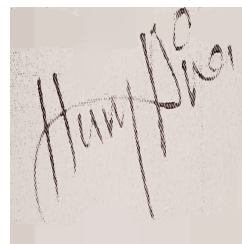
| Code             | Generic                                                    | Dosage                               | Duration | Instructions                                        |
|------------------|------------------------------------------------------------|--------------------------------------|----------|-----------------------------------------------------|
| 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                         |
| 0207-533801-1451 | (ESOMEPRAZOLE (AS MAGNESIUM : 20 MG CAPSULES (HARD GELATIN | CAPSULES (HARD GELATIN (14S, BLISTER | 7        | Take 1Capsule 2 Time(s) per Day For 7 Day(s) others |
| 0139-116206-1171 | (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS  | TABLETS (14S, BLISTER PACK)          | 7        | Take 1Tablets 1 Time(s) per Day For 7 Day(s) others |

| Code             | Generic                                         | Dosage                                  | Duration | Instructions                                        |
|------------------|-------------------------------------------------|-----------------------------------------|----------|-----------------------------------------------------|
| 0005-107001-0051 | (CAFFEINE : 65 MG (PARACETAMOL : 500 MG CAPLETS | CAPLETS (24S, BOX                       | 6        | Take 1Tablets 2 Time(s) per Day For 6 Day(s) others |
| 0195-123701-0391 | (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS    | FILM COATED TABLETS (10S, BLISTER PACK) | 10       | Take 1Tablet at night                               |

Date: 01-01-25(dd/mm/yy)

Doctor's Name Humaira

Signature and Stamp



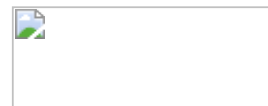
Dr. Humaira Mumtaz  
General Practitioner  
DHA No: 54155530-002  
CITICARE MEDICAL CENTER LLC  
DUBAI - U.A.E.

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: 01-01-25(dd/mm/yy)

Signature of Insured / Claimint

Copy of NGI - Pharmacy

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

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