1.HealthNet Policy Number I038-000-116276447-01 2. Authorization Code:

2.Patient Name MAHMOUD YASSER ALSHIKH MAHMOUD

3.Patient Date of Birth & Sex 22-09-93(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0505441750

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

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

7.Presenting Complaints:

PC ; SORE THROAT , SEVER BODY PAIN ,ASOCIATED WITH HIGH GRADE FEVER AND SHIEVERING FOR 1 DAY

COUGH WITH YELLOW SPUTUM , RUNNY NOSE WATERY EYES

ORAL INTAKE REDUCED

NAUSEA

O/ E ; LOOK LETHARGIC , DEHYDRATED

HYPEREMIC PHARYNX

CHEST WHEEZING

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiAcute pharyngitis, unspecified, Fever, unspecified, Acute upper respiratory infection, unspecified, Dehydration, Cough, Pain, unspecified, Allergic rhinitis, unspecified ICD Code J02.9, R50.9, J06.9, E86.0, R05, R52, J30.9

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureCEFTRIAXONE-TABUK IV,PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION,Blood Count Complete Auto&Auto Difrntl Wbc Count,C-Reactive Protein High Sensitivity,INJ-HYDROCORTISONE 250 MG/2ML,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 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.,Intramuscular injection,nebulization with ventoline solution,PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,Administered intravenously,LACTATED RINGERS INJECTION USP-(CALCIUM CHLORIDE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION FOR INFUSION,(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION

CPT code0195-107704-0801,2190-106618-1001,0027-142201-0831,85025,86141,INJ016,9,96372,94640,0188-135906-2441,96365,0102-152902-1001,0005-150403-1021

b.Laboratiry Test:

c.Radiology / Investigations:

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

16.

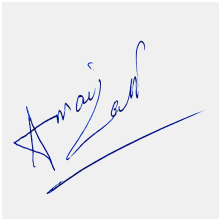
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0219-533801-0392	(ESOMEPRAZOLE (AS MAGNESIUM : 20 MG FILM COATED TABLETS	FILM COATED TABLETS (28S, HDPE BOTTLE	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) morning empty stomach
0031-168201-0391	(DOMPERIDONE : 10 MG FILM COATED TABLETS	FILM COATED TABLETS (30S, BLISTER PACK	3	Take 1Tablets 1 Time(s) per Day For 3 Day(s) before meal
3819-373201-0391	(TOLPERISONE HCL : 150 MG) FILM COATED TABLETS	FILM COATED TABLETS (30S, BLISTER)	3	Take 1Tablets 1 Time(s) per Day For 3 Day(s) after meal
0006-106601-0393	(PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (48S, BLISTER PACK)	5	Take 1Tablets 3 Time(s) per Day For 5 Day(s) after meal

Code	Generic	Dosage	Duration	Instructions
0397-116207-0391	(AMOXICILLIN : 500 MG (CLAVULANIC ACID : 125 MG FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal
0195-123701-0391	(CETIRIZINE HCL : 10 MG FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) evening

Date: 11-02-25(dd/mm/yy)

Signature and Stamp



Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Doctor's Name DR Amaizah

Physician Code DHA-P-98486553 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: 11-02-25(dd/mm/yy) Signature of Insued / Claimint

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HealthNet