1.HealthNet Policy Number I038-000-116927662-01 2. Authorization Code:

2.Patient Name GENE MICHAEL ZABALLERO ARRIETA

3.Patient Date of Birth & Sex 28-05-90(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0501961139

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

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

7.Presenting Complaints:

: SORE THROAT, BODY PAIN . WEAKNESS STARTED 21/02/25

FLANKS PAIN AND BURNING MICTURATION STARTED 23/02/25

O/E

LOOK LETHARGI, DEHYDRATED

HYPEREMIC PHARYNX

CHEST IS CLEAR

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiPain, unspecified, Dehydration, Urinary tract infection, site not specified, Dysuria ICD Code R52, E86.0, N39.0, R30.0

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureUrnls Dip Stick/Tablet Reagent Auto Microscopy,LACTATED RINGERS INJECTION USP,Administered intravenously,CEFTRIAXONE-TABUK IV,9.019.01 - (9.01) - Follow Up - Consultation GP - (AED 0.0000),(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,SCOPINAL-(HYOSCINE : 20 MG/ML) SOLUTION FOR INJECTION,Intramuscular injection CPT code81001,0102-152902-1001,96365,0195-107704-0801,9.01,0031-149902-1021,0005-136504-1021,96372

b.Laboratiry Test:

c.Radiology / Investigations:

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

16.

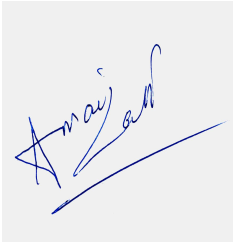
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0005-136501-0391	(HYOSCINE : 10 MG FILM COATED TABLETS	FILM COATED TABLETS (1000S, BLISTER PACK	3	Take 1Tablets 2 Time(s) per Day For 3 Day(s) others
1947-548101-0081	(CRANBERRY EXTRACT : 120 MG) CHEWABLE TABLETS	CHEWABLE TABLETS (14S, BLISTER)	5	Take 1Tablets 3 Time(s) per Day For 5 Day(s) others

Date: 24-02-25(dd/mm/yy)

Doctor's Name DR Amaizah

Signature and Stamp



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

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: 24-02-25(dd/mm/yy) Signature of Insued / Claimint

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