1.HealthNet Policy Number: I038-000-115298135-01 2. Authorization Code:

2.Patient Name: IKECHUKWU VICTOR NDUCHE

3.Patient Date of Birth & Sex: 13-09-85(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0555891985

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

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

7.Presenting Complaints:

PC : LOWER BACK PAIN ASSOCIATED WITH BENDING

PAIN IN LOWER RIBS BILATERAL STARTED 25/02/25

O/E ; TENDERNESS AT LOWER BACK

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiPain, unspecified, Low back pain ICD Code R52, M54.5

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureCLOFEN ,Intramuscular injection,Free follow-up consultation of the same diagnosis within 7 days of initial consultation by a General Practitioner. CPT code0005-149902-1021,96372,9.1

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
0186-143701-0062	(CELECOXIB : 200 MG CAPSULES	CAPSULES (30S, BLISTER PACK	3	Take 1Tablets 1 Time(s) per Day For 3 Day(s) others
0027-142201-0832	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	POWDER FOR SOLUTION (9S, SACHET)	2	Take 1sachet 1Time(s) perDay For 2 Day(s) others
2093-596002-0431	(DICLOFENAC DIETHYLAMINE : 23.2 MG / G GEL	GEL (50G, TUBE	3	Take 1Gel 2Time(s) perDay For 3 Day(s) others
2150-575201-1171	(CALCIUM : 400 MG (VITAMIN D3 : 200 IU (MAGNESIUM : 100 MG (ZINC : 4 MG TABLETS	TABLETS (30S, BOX	30	Take 1Tablets 1Time(s) perDay For 30 Day(s) after meal

Date: 26-02-25(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: 26-02-25(dd/mm/yy) Signature of Insued / Claimint

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