



1. HealthNet Policy Number

2. Patient Name

3. Patient Date of Birth & Sex

5. Nature of illness or Injury

6. Are You the patient's primary physician

7. Presenting Complaints:

C ; HEADACHE , BODY PAIN , COUGH WITH SPUTUM , GREEN IN COLOR

NASAL CONGESTION

ASSOCIATED WITH HIGH GRADE FEVER

O/E :

LOOK RESTLESS , DEHYDRATED ,

HYPEREMIC PHARYNX

CHEST CONGESTED

8. Duration of Symptoms:

9. Onset of Condition:

10. Relevant Past Medical/Surgical History

Diagnosis: Acute upper respiratory infection, unspecified, Allergic rhinitis, unspecified, Acute pansinusitis, unspecified, Fever, unspecified

12. Etiology:

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

14. Plan / Details of Management

a. Procedure: nebulization with ventoline solution, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION, (DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION, Intramuscular injection, 9.019.01 - (9.01) - Follow Up - Consultation GP - (AED 0.0000), (CHLORPHENIRAMINE : 10 MG) INJECTION

b. Laboratory Test:

c. Radiology / Investigations:

15. In Case of Hospitalization: Date of Admission:

1038-000-

122088949-01

2. Authorization

Code:

THAMEESHA IVANJANA

07-03-99(dd/mm/yy)

☒ Male ☐ Female

Mobile No. 05584802626

☐ Acute ☐ Chronic ☐ Emergency

☐ Yes ☐ No

ICD Code J06.9, J30.9, J01.40, R50.9

CPT code 94640, 0188-135906-2441, 0031-149902-1021, 0125-122107-1022, 96372, 9.01, 0046-111801-0511

Date of Discharge:

16.

PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
No Prescriptions History Found				

Date: 27-02-25(dd/mm/yy)

Doctor's Name DR Amaizah

Physician Code DHA-P-98486553 HNM Code

Signature and Stamp

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

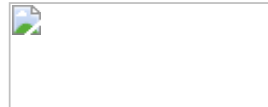
Authorization

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: 27-02-25(dd/mm/yy)

Signature of Insured / Claimant



Copy of NGI - Pharmacy

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

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