1.HealthNet Policy Number I038-000-118180006-01 2. Authorization Code:

2.Patient Name ABDULRAHMAN MUSA BALA

3.Patient Date of Birth & Sex 20-07-89(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0582130863

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

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

7.Presenting Complaints:

PATIENT CAME WITH HIGH GRADE FEVER ,BODY PAIN ,WEAKNESS .FOR TWO DAYS

ON EX.THROAT IS HYPEREMIC

CHEST IS CONGESTED

PT IS PALE AND DEHYDRATED

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiAcute upper respiratory infection, unspecified, Cough, Fever, unspecified, Dehydration, Pain, unspecified ICD Code J06.9, R05, R50.9, E86.0, R52

12.Etiology:

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

14.Plan / Details of Management

a.Procedure(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,Intramuscular injection,Administered intravenously,PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,nebulization with ventoline solution CPT code0195-107704-0801,0125-122107-1022,2190-106618-1001,96372,96365,0188-135906-2441,94640

b.Laboratiry Test:

c.Radiology / Investigations:

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

16.

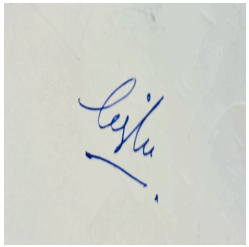
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
No Prescriptions History Found				

Date: 20-03-25(dd/mm/yy)

Doctor's Name AISHA

Signature and Stamp



Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Physician Code DHA-P-40131439 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: 20-03-25(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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