1.HealthNet Policy Number I038-000-113920552-01 2. Authorization Code:

2.Patient Name OLUMIDE PETER AWE

3.Patient Date of Birth & Sex 01-01-84(dd/mm/yy) ☑ Male ☐ Female

Mobile No.501394295

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

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

7.Presenting Complaints:

fever

abdominal pain since after lunch today

had vegetable biryani in the lunch

nausea

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiBacterial foodborne intoxication, unspecified, Fever, unspecified, Generalized abdominal pain ICD Code A05.9, R50.9, R10.84

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureGp Consultation CPT code9

b.Laboratiry Test:

c.Radiology / Investigations:

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

16.

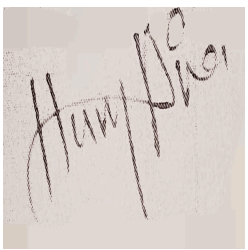
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0097-103202-0392	(CIPROFLOXACIN : 250 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	3	Take 1Tablets 2 Time(s) per Day For 3 Day(s) others
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
0031-168201-0391	(DOMPERIDONE : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (30S, BLISTER PACK)	3	Take 1Tablets 2 Time(s) per Day For 3 Day(s) before meal
0006-106601-0393	(PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (48S, BLISTER PACK)	3	Take 1Tablets 3 Time(s) per Day For 3 Day(s) others

Date: 27-03-25(dd/mm/yy)

Doctor's Name Humaira

Signature and Stamp



Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Physician Code DHA-P-54155530 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: 27-03-25(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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HealthNet