1.HealthNet Policy Number I038-000-120183510-01 2. Authorization Code:

2.Patient Name ABDUL MAJEED MUHAMMAD ISMAIL

3.Patient Date of Birth & Sex 01-05-78(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0527139519

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

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

7.Presenting Complaints:follow up

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiAcute upper respiratory infection, unspecified, Fever, unspecified, Nasal congestion, Cough ICD Code J06.9, R50.9, R09.81, R05

12.Etiology:

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

14.Plan / Details of Management

a.Procedurenebulization with ventoline solution,VENTOLIN NEBULES,Free follow-up consultation of the same diagnosis within 7 days of initial consultation by a General Practitioner. CPT code94640,0006-402803-2071,9.1

b.Laboratiry Test:

c.Radiology / Investigations:

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

16.

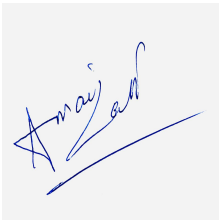
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0397-116207-0391	(AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP)	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal
0027-142201-0831	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	POWDER FOR SOLUTION (30S, SACHET)	3	Take 1sachet 1 Time(s) per Day For 3 Day(s) after meal
3819-373201-0391	(TOLPERISONE HCL : 150 MG) FILM COATED TABLETS	FILM COATED TABLETS (30S, BLISTER)	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) after meal

Date: 21-04-25(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: 21-04-25(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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