1.HealthNet Policy Number I038-000-115298166-01 2. Authorization Code:

2.Patient Name ZAKARIA ABDELHAI

3.Patient Date of Birth & Sex 11-03-94(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0501989306

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

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

7.Presenting Complaints:

vomiting one time today

dizziness

headache

weakness

dry lips

o/e dehydrated

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiVomiting, unspecified, Dizziness and giddiness, Weakness, Dehydration, Headache, unspecified ICD Code R11.10, R42, R53.1, E86.0, R51.9

12.Etiology:

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

14.Plan / Details of Management

a.ProcedurePREMOSAN ,LACTATED RINGERS INJECTION USP,IV fluid admisitration,CLOFEN ,Gp Consultation,Intravenous Injection CPT code0005-150403-1021,0439-152905-1001,96360,0005-149902-1021,9,96374

b.Laboratiry Test:

c.Radiology / Investigations:

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

16.

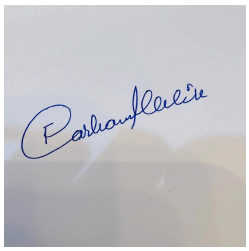
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
6619-608703-0831	(SODIUM CHLORIDE : 0.52 G) (POTASSIUM CHLORIDE : 0.3 G) (SODIUM CITRATE : 0.58 G) (GLUCOSE ANHYDROUS : 2.7 G) POWDER FOR SOLUTION	POWDER FOR SOLUTION (10 X 4.4 G, SACHET)	3	Take 1sachet 1 Time(s) per Day For 3 Day(s) others
5252-627601-0391	(ONDANSETRON (AS HCL) : 4 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER)	3	Take 1Tablets 2Time(s) perDay For 3 Day(s) before meal
0135-223401-1171	(NAPROXEN : 500 MG) TABLETS	TABLETS (10S, BLISTER PACK)	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others

Date: 12-05-25(dd/mm/yy)

Doctor's Name Dr.Farhan Iyas

Signature and Stamp



Dr .Frahan Ilyas Malik
Physician-General Practitioner
DHA-06441782-001
CITICARE MEDICAL CENTER
DUBAI U.A.E

Physician Code DHA-P-6441782 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: 12-05-25(dd/mm/yy) Signature of Insued / Claimint

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