1.HealthNet Policy Number I038-000-118599487-01 2. Authorization Code:

2.Patient Name HAMMAD HASSAN CHOUDHARY MUHAMMAD FAROOQ AHMED CHOUDHARY

3.Patient Date of Birth & Sex 13-10-85(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0523723000

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

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

7.Presenting Complaints:

Pt came for followup

S.Uric acid 7.67

CRP 23

WBC 16000

Total cholesterol 222

Vit d3 14.2

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiAcute pharyngitis, unspecified, Cough, Vitamin D deficiency, unspecified, Hyperlipidemia, unspecified, Hyperuricemia w/o signs of inflam arthrit and tophaceous dis ICD Code J02.9, R05, E55.9, E78.5, E79.0

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureCEFTRIAXONE-TABUK IV,VITAMIN D, INJECTION ,Administered intravenously,9.019.01 - (9.01) - Follow Up - Consultation GP - (AED 0.0000) CPT code0195-107704-0801,INJ064,96365,9.01

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
0003-375702-0391	(FEBUXOSTAT : 120 MG) FILM COATED TABLETS	FILM COATED TABLETS (28S, BLISTER)	14	Take 1Tablets 1 Time(s) per Day For 14 Day(s) others
2693-382607-0971	(ERGOCALCIFEROL (VITAMIN D2) : 50000 IU) SOFT GELATIN CAPSULES	SOFT GELATIN CAPSULES (12S, HDPE BOTTLE)	8	Take 1Tablets 1 Time(s) per Week For 8 Day(s) others

Date: 09-08-25(dd/mm/yy)

Signature and Stamp

د. كيرثانا راني باديبورايل ثارا
Dr. Keerthana Rani Padippurayil Thara
General Practitioner
License No.: 37864046-001
مركز سيتيكير الطبي ذ م م
CITICARE MEDICAL CENTER LLC

Doctor's Name KEERTHANA

Physician Code DHA-P-37864046 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: 09-08-25(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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