1.HealthNet Policy Number I038-000-116994295-01 2. Authorization Code:

2.Patient Name JAYAWEERA GAYAN KUMARA SELLAHANDI

3.Patient Date of Birth & Sex 20-12-83(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0524569919

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

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

7.Presenting Complaints:co headache redness of both eyes oe both eyes are red itching in eyes vitals stable

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiEssential (primary) hypertension, Ocular pain, unspecified eye ICD Code I10, H57.10

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureOffice consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patients and/or familys needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family. 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
0207-379202-1171	(AMLODIPINE (AS BESYLATE) : 10 MG) TABLETS	TABLETS (30S, BLISTER)	30	Take 1Tablets 1Time(s) perDay For 30 Day(s) others
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	7	Take 1Drops 1 Time(s) per Day For 7 Day(s) others
0085-239201-0371	(DEXAMETHASONE : 0.10%) (TOBRAMYCIN : 0.3%) EYE DROPS	EYE DROPS (5ML, DROPPER BOTTLE)	1	Take 2Drops 3 Time(s) per Day For 1 Day(s) others

Date: 02-05-24(dd/mm/yy)

Doctor's Name Humaira

Signature and Stamp

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: 02-05-24(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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

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