



1.HealthNet Policy Number

I038-000-
118933628-012.
Authorization
Code:

2.Patient Name

SHAMNAS KOTTAYIL YOUSEF YOUSEF

3.Patient Date of Birth & Sex

15-03-97(dd/mm/yy)

☒ Male ☐
Female

Mobile No.0529901639

5.Nature of illness or Injury

☐ Acute ☐ Chronic ☐ Emergency

6.Are You the patient's primary physician

☐ Yes ☐ No

7.Presenting Complaints:co knife cut wound on his left thumb 1 day before

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevant Past Medical/Surgical History

DiagnosisLaceration w fb of right thumb w damage to nail, init

ICD Code S61.121A

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureINJ-TETANUS TOXOID,(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,Office 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 families 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.,Intramuscular injection

CPT codeINJ017,0195-107704-
0802,9,96372

b.Laboratory Test:

c.Radiology / Investigations:

15.In Case of Hospitalization: Date of Admission:

Date of Discharge:

16.

PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0281-128401-0152	(FUSIDIC ACID : 2%) CREAM	CREAM (30G, COLLAPSIBLE TUBE)	1	Take 1Cream 1Time(s) perDay For 1 Day(s) others
0005-107001-0051	(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others
0248-187801-1171	(DILOXANIDE FUROATE : 250 MG) (METRONIDAZOLE : 200 MG) TABLETS	TABLETS (20S, BLISTER PACK)	7	Take 1Tablets 3 Time(s) per Day For 7 Day(s) others
0005-143601-0391	(CEFUROXIME : 250 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others

Date: 03-05-24(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: 03-05-24(dd/mm/yy)

Signature of Insured / Claimint

Copy of NGI - Pharmacy

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

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