



1.HealthNet Policy Number

I038-000-  
118115464-012.  
Authorization  
Code:

2.Patient Name

SONIKA GURUNG

3.Patient Date of Birth &amp; Sex

16-03-99(dd/mm/yy)

☐ Male ☒ Female

5.Nature of illness or Injury

Mobile No.0555701723

6.Are You the patient's primary physician

☐ Acute ☐ Chronic ☐ Emergency

7.Presenting Complaints:

☐ Yes ☐ No

Fever since the past 3 days,

Now feels dizzy today and feels like vomiting.

Has aversion to food.

Also frequency of urine.

Does not have any other medical condition in the past, not hypertensive and not diabetic.

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevant Past Medical/Surgical History

Diagnosis: Acute upper respiratory infection, unspecified, Urinary tract infection, site not specified, Dizziness and giddiness

ICD Code J06.9, N39.0, R42

12.Etiology:

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

14.Plan / Details of Management

a.Procedure: Blood Count Complete Auto&Auto Differntl Wbc Count,C-Reactive Protein,Sedimentation Rate Rbc Automated,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.

CPT code 85025,86140,85652,9

b.Laboratory Test:

c.Radiology / Investigations:

15.In Case of Hospitalization: Date of Admission:

Date of Discharge:

16.

## PRESCRIPTION WITH DOSAGE &amp; DURATION

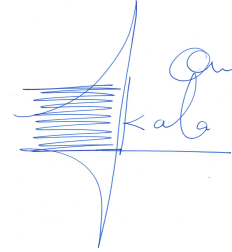
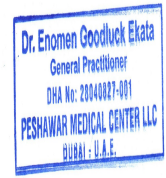
| Code             | Generic                                              | Dosage                     | Duration | Instructions                                       |
|------------------|------------------------------------------------------|----------------------------|----------|----------------------------------------------------|
| 0027-128802-2021 | (XYLOMETAZOLINE HYDROCHLORIDE : 0.1%)<br>NASAL DROPS | NASAL DROPS (10ML, BOTTLE) | 7        | Take 2 Drops 2 Time(s) per Day For 7 Day(s) others |

| Code             | Generic                                                                                        | Dosage                                  | Duration | Instructions                                             |
|------------------|------------------------------------------------------------------------------------------------|-----------------------------------------|----------|----------------------------------------------------------|
| 0195-123701-0391 | (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS                                                   | FILM COATED TABLETS (10S, BLISTER PACK) | 10       | Take 1Tablets 1 Time(s) per Day For 10 Day(s) others     |
| 0005-119805-1172 | (PREDNISOLONE : 5 MG) TABLETS                                                                  | TABLETS (20S, BLISTER PACK)             | 5        | Take 2Tablets 1 Time(s) per Day For 5 Day(s) after meal  |
| 2027-560101-0392 | (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS                                | FILM COATED TABLETS (16S, BLISTER)      | 8        | Take 1Tablets 2 Time(s) per Day For 8 Day(s) after meal  |
| 0252-185801-0391 | (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS | FILM COATED TABLETS (20S, BLISTER PACK) | 10       | Take 1Tablets 2 Time(s) per Day For 10 Day(s) after meal |

Date: 17-05-24(dd/mm/yy)

Doctor's Name Enomen Goodluck

Signature and Stamp

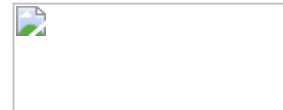



Physician Code DHA-P-28040827 HNM Code

#### 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: 17-05-24(dd/mm/yy) Signature of Insured / Claimint

Copy of NGI - Pharmacy

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

NGI House Building, P.O. Box 154, Deira, Dubai, Tel: +971 4 211 5800, Fax: +971 4 250 2854, Email: ngico@emirates.net.ae, Website: www.ngi.ae

