1.HealthNet Policy Number I038-000-118712256-01 2. Authorization Code:

2.Patient Name LIAQAT ALI KHAN MOMIN KHAN

3.Patient Date of Birth & Sex 01-01-92(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0555970161

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

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

7.Presenting Complaints:

Diarrhea, fever, and vomiting.

Had previously visited Aster clinic but symptoms has persisted.

CBC report seen is normal.

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiAcute gastritis without bleeding, Infectious gastroenteritis and colitis, unspecified, Fever, unspecified, Vomiting, unspecified, Diarrhea, unspecified

ICD Code K29.00, A09, R50.9, R11.10, R19.7

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureAdministered intravenously,CLOFEN ,Intramuscular injection,METRONIDAZOLE : 500 MG/100ML) SOLUTION FOR INFUSION ,SERVICE CHARGE,(METOCLOPRAMIDE HCL : 10 MG/2ML) SOLUTION FOR INJECTION,LACTATED RINGERS INJECTION USP,PANTONIX 40MG I.V.,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 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 code96365,0005-149902-1021,96372,0002-116601-1001,SC,1528-378102-1021,0102-152902-1001,0005-242802-0781,9

b.Laboratiry Test:

c.Radiology / Investigations:

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

16.

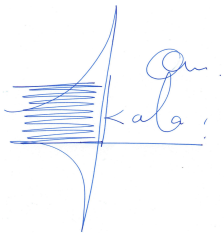
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0005-150407-1172	(METOCLOPRAMIDE : 10 MG) TABLETS	TABLETS (20S, BLISTER PACK)	3	Take 1Tablets 3Time(s) perDay For 3 Day(s) before meal
1516-107902-1171	(IBUPROFEN : 400 MG) TABLETS	TABLETS (24S, BLISTER PACK)	3	Take 1Tablets 2 Time(s) per Day For 3 Day(s) after meal
0188-232401-0391	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	FILM COATED TABLETS (14S, BLISTER PACK)	7	Take 1Tablets 2Time(s) perDay For 7 Day(s) before meal
5098-116604-1171	(METRONIDAZOLE : 500 MG) TABLETS	TABLETS (20S, BLISTER)	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal
0054-103201-0391	(CIPROFLOXACIN : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	Take 1Tablets 2Time(s) perDay For 5 Day(s) after meal

Date: 22-05-24(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: 22-05-24(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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HealthNet