



1.HealthNet Policy Number

2.Patient Name

3.Patient Date of Birth & Sex

5.Nature of illness or Injury

6.Are You the patient's primary physician

7.Presenting Complaints:

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevant Past Medical/Surgical History

12.Etiology:

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

14.Plan / Details of Management

15.In Case of Hospitalization: Date of Admission:

16.

I038-000-120183374-01

VESH BAHADUR GURUNG

12-11-00(dd/mm/yy)

Mobile No.0562562509

Acute Chronic Emergency

Yes No

ICD Code J20.9, R05

CPT code9

Date of Discharge:

2. Authorization Code:

☒ Male ☐ Female

Cough since the past one week.

Had fever at about the same time as onset of cough but fever has now subsided.

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 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.

b.Laboratory Test:

c.Radiology / Investigations:

Code	Generic	Dosage	Duration	Instructions
0097-127405-0392	(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (6S, BLISTER)	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) after meal
0027-265802-1161	(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	SYRUP (200ML, BOTTLE)	7	Take 10ML 3Time(s) perDay For 7 Day(s) after meal
0070-148701-1171	(LORATADINE : 10 MG) TABLETS	TABLETS (10S, BLISTER PACK)	10	Take 1Tablets 1 Time(s) per Day For 10 Day(s) others

Date: 26-06-24(dd/mm/yy)

Doctor's Name Enomen Goodluck

Signature and Stamp



Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

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: 26-06-24(dd/mm/yy)

Signature of Insured / Claimint

Copy of NGI - Pharmacy

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

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