

1.He	althNet Policy	Number			1038-0 11529	000- 8176-01	Author Code:	ization	
2.Pa	tient Name	MAIM	MAIMUNA SSEREMBA NAKANJAKO						
3.Pa	Patient Date of Birth & Sex				02-06-	02-06-83(dd/mm/yy)		☐ Male <a>✓ Female	
					Mobi	le No.052	5263449		
5.Na	Nature of illness or Injury					☐ Acute ☐ Chronic ☐ Emergency			
6.Ar	Are You the patient's primary physician					☐ Yes ☐ No			
7.Pre	esenting Comp	aints:							
PC: t	ooth pain since	e the past 2 days.							
Exan	nination: cariou	us 2nd and 3rd uppe	er molar.						
Plan	: Refer to denti	st.							
8.Du	ration of Symp	toms:							
9.On	set of Conditio	n:							
10.R	elevent Past M	edical/Surfgical Hist	ory						
Diag	onosisiDental ca	aries, unspecified, Pain,	, unspecified		ICD C	ode K02.9), R52		
	tiology:								
		:mode of Injury/plac	ce of Injury						
	lan / Details of	_							
k S C a	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) CPT code9 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.								
k	.Laboratiry Test:								
C	Radiology / In	vestigations:							
15.In Case of Hospitalization: Date of Addmission: Date of Discharge:									
16.			PRESCRIPTIO	N WITH DOSAGE & DURATION	NC				
	Code	Generic		Dosage	Duration	Instructi	ons		

POWDER FOR

SOLUTION (9S, SACHET)

3

(DICLOFENAC POTASSIUM: 50 MG)

POWDER FOR SOLUTION

0027-

142201-0832

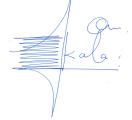
Take 1Powder 3 Time(s) per Day

For 3 Day(s) after meal

28-06-24(dd/mm/yy) Date:

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

28-06-24(dd/mm/yy) Signature of Insued / Claimint Date:

Copy of NGI - Pharmacy

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



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