1.HealthNet Policy Number	I038-000-115298246-01	2. Authorization Code:
2.Patient Name	GLENN MARK RIVERA TABAY	
3.Patient Date of Birth & Sex	16-07-89(dd/mm/yy)	☑ Male ☐ Female
	Mobile No.0545109007	
5.Nature of illness or Injury	☐ Acute ☐ Chronic ☐ Emergency	
6.Are You the patient's primary physician	☐ Yes ☐ No	

7.Presenting Complaints:

PC: ALLERGIC REACTION TO UNSPECIFIED THING

WEAKNESS

ITCHING

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiAllergic contact dermatitis due to other agents, Dehydration, Muscle weakness (generalized)	ICD Code L23.89, E86.0, M62.81

12.Etiology:

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

14.Plan / Details of Management

a.Procedure(SODIUM CHLORIDE : 0.9%) (DEXTROSE : 5%) SOLUTION FOR INFUSION,9.019.01 - (9.01) - Follow Up - Consultation GP - (AED 0.0000),CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,Intramuscular injection,(CIPROFLOXACIN : 0.2%) SOLUTION FOR INFUSION,Administered intravenously	CPT code0102-100104-1001,9.01,0005-111805-1021,0125-122107-1022,96372,0327-103208-1001,96365

b.Laboratiry Test:

c.Radiology / Investigations:

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

16.

PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0195-123701-0391	CETIRIZINE HCL	Tablet	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) evening BEFORE SLEEP
0027-109206-0151	(TERBINAFINE (AS HCL) : 1%) CREAM	CREAM (15G, TUBE)	7	Take 1Cream 2 Time(s) per Day For 7 Day(s) others
0252-140201-0061	(FLUCONAZOLE : 150 MG) CAPSULES	CAPSULES (1S, BLISTER PACK)	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) others

Date: 10-08-24(dd/mm/yy)

Signature and Stamp

Doctor's Name AHSAN HUSSAIN

Physician Code DHA-P-87543658 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: 10-08-24(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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

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