1.HealthNet Policy Number I038-000-119318469-01 2. Authorizatio Code:

2.Patient Name ANIS ISMOLIZODA

3.Patient Date of Birth & Sex 13-09-01(dd/mm/yy) ☑ M Fema

Mobile No.0562800706

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

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

7.Presenting Complaints:

co red eyes both pain in both eyes 18th august 2024

oe both eyes are red

chest is clear no added sounds

restless

taking penadol at home

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiUnspecified acute conjunctivitis, bilateral ICD Code H10.33

12.Etiology:

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

14.Plan / Details of Management

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 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 code9

b.Laboratiry Test:

c.Radiology / Investigations:

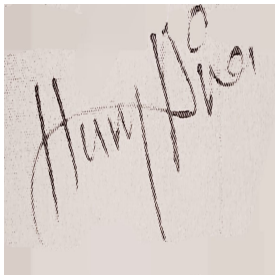
15.In Case of Hospitalization: Date of Addmission: Date of Discharge:

16. **PRESCRIPTION WITH DOSAGE & DURATION**

Code	Generic	Dosage	Duration	Instructions
0027-142201-0832	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	POWDER FOR SOLUTION (9S, SACHET)	3	Take 1Drops 2 Tin Day For 3 Day(s) c
0085-125903-0372	(MOXIFLOXACIN (AS HCL) : 0.5%) EYE DROPS	EYE DROPS (5ML, DROPPER BOTTLE)	1	Take 2 drops 2 tin
0085-227402-0372	(NAPHAZOLINE : 0.025%) (PHENIRAMINE MALEATE : 0.3%) EYE DROPS	EYE DROPS (15ML, DROPPER BOTTLE)	1	Take 1Drops 1 Tin Day For 1 Day(s) c

Date: 23-08-24(dd/mm/yy)

Signature and Stamp



Doctor's Name Humaira

Physician Code DHA-P-54155530 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 me examination / investigation / therapy is given to me by the doctor. I hereby authorize any Hospital, Physician, Pharmacy or any other per provided medical services to me or my dependents to furnish NGI with any and all information with regard to any medical history, medi 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: 23-08-24(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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

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