



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.

I038-000-115298013-01

2. Authorization Code:

NITHIN KUMAR THEKKE KARA

26-06-90(dd/mm/yy)

☒ Male ☐ Female

Mobile No.0525406602

☐ Acute ☐ Chronic ☐ Emergency

☐ Yes ☐ No

ICD Code L29.9, L23.9

CPT code0005-111805-1021,96372,9

Date of Discharge:

co itching all over the body rash on the face 3rd sep. 2024

oe

chest is clear no added sounds

restless

DiagnosisiPruritus, unspecified, Allergic contact dermatitis, unspecified cause

a.ProcedureCHLOROHISTOL 10MG, Intramuscular injection,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.

b.Laboratiry Test:

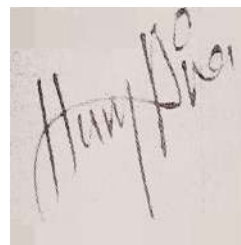
c.Radiology / Investigations:

PRESCRIPTION WITH DOSAGE & DURATION				
Code	Generic	Dosage	Duration	Instructions
0220-137301-2571	(CALAMINE : N/A) TOPICAL LOTION	TOPICAL LOTION (100ML, BOTTLE)	5	Take 1Lotion 1 Time(s) per Day For 5 Day(s) others
0006-131401-0151	BETAMETHASONE	Cream	1	Take 1Cream 1Time(s) perDay For 1 Day(s) others
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) others

Date: 06-09-24(dd/mm/yy)

Doctor's Name Humaira

Signature and Stamp



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 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: 06-09-24(dd/mm/yy)

Signature of Insured / Claimant



Copy of NGI - Pharmacy

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

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