



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:

I038-000-115298176-01

2. Authorization Code:

MAIMUNA SSEREMBA NAKANJAKO

02-06-83(dd/mm/yy)

☐ Male ☒ Female

Mobile No.0525263449

☐ Acute☐ Chronic☐ Emergency

☐ Yes☐ No

PC: FEVER

FLU

LOW BACK PAIN

EPIGASTRIC PAIN

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevant Past Medical/Surgical History

DiagnosisAcute upper respiratory infection, unspecified, Acute nasopharyngitis [common cold], Low back pain, Muscle spasm of back, Gastro-esophageal reflux disease without esophagitis

ICD Code J06.9, J00, M54.5, M62.830, K21.9

12.Etiology:

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

14.Plan / Details of Management

a.Procedure(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,nebulization with ventoline solution,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.

CPT code0188-135906-2441,94640,9

b.Laboratiry Test:

c.Radiology / Investigations:

15.In Case of Hospitalization: Date of Admmission:

Date of Discharge:

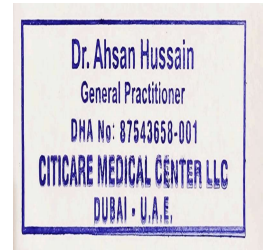
16.	PRESCRIPTION WITH DOSAGE & DURATION				
Code	Generic	Dosage	Duration	Instructions	
0186-143701-0062	(CELECOXIB : 200 MG) CAPSULES	CAPSULES (30S, BLISTER PACK)	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal	
0252-185801-0391	(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal	

Code	Generic	Dosage	Duration	Instructions
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) evening
0195-123701-0391	CETIRIZINE HCL	Tablet	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) evening BEFORE SLEEP

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

Doctor's Name AHSAN HUSSAIN

Signature and Stamp

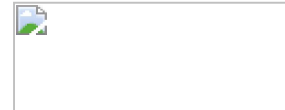


Physician Code DHA-P-87543658 HNM Code

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

Signature of Insured / Claimint

Copy of NGI - Pharmacy

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

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