

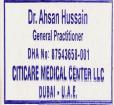
1.Hea	lthNet Policy N	umber			1038-000- 120121278-01	2. Autho Code:	rization		
2.Pati	ent Name	SHAHAN ANWAR ANWAR HUSSAIN JAVED							
3.Pati	ent Date of Birt	:h & Sex			29-12-89(dd/mm/yy)				
					Mobile No.055	7868506			
5.Nat	ure of illness or	Injury		☐ Acute ☐ Chronic ☐ Emergency					
6.Are	You the patient	t's primary physic	☐ Yes ☐ No						
7.Pres	senting Compla	ints:							
co fev	er on and offSv	velling and pain on	the right buttocks 21st o	ct 2024					
oe che	est is clear no add	ed sounds							
restles	S								
8.Dur	ation of Sympto	oms:							
9.Ons	et of Condition	:							
10.Re	levent Past Me	dical/Surfgical His	story						
Diago	nosisiCellulitis o	f buttock, Fever, uns	ICD Code L03.317, R50.9, R52						
12.Eti	ology:								
13.ln	case of Injury:n	node of Injury/pla	ace of Injury						
14.Pla	an / Details of N	lanagement (
a.Procedure9.019.01 - (9.01) - Follow Up - Consultation GP - (AED 0.0000),TRIAXONE I.V(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,CLOFEN - (DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,Administered intravenously,Intramuscular injection					CPT code9.01,0005-107704-0802,2190-106618- 1001,0005-149902-1021,96365,96372				
b.I	Laboratiry Test:								
c.l	Radiology / Inv	estigations:							
15.In	15.In Case of Hospitalization: Date of Addmission:					Date of Discharge:			
16.	16. PRESCRIPTION WITH DOSAGE & DURATION								
ll	Code	Generic	Dosage	Duration	In	structions			
	No Prescriptions History Found								
Date:	:	26-10-24(dd/	mm/yy)		A		r. Ahsan Hussain General Practitioner		

Signature and Stamp

Physician Code DHA-P-87543658 HNM Code

AHSAN HUSSAIN





Authorization

Doctor's Name

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:

Copy of NGI - Pharmacy

26-10-24(dd/mm/yy)

Signature of Insued / Claimint



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