



1. HealthNet Policy Number

I038-000-
116849438-01

2.
Authorization
Code:

2. Patient Name

ABDUL KABIR ABDUL NASEER AWAN

3. Patient Date of Birth & Sex

01-01-94(dd/mm/yy)

☒ Male ☐
Female

Mobile No. 0529544196

5. Nature of illness or Injury

☐ Acute ☐ Chronic ☐ Emergency

6. Are You the patient's primary physician

☐ Yes ☐ No

7. Presenting Complaints:

PC: FEVER

FLU

SORE THROAT

COUGH

LOW BACK PAIN

8. Duration of Symptoms:

9. Onset of Condition:

10. Relevant Past Medical/Surgical History

Diagnosis: Acute upper respiratory infection, unspecified, Acute nasopharyngitis [common cold], Fever, unspecified, Acute bronchitis, unspecified, Low back pain

ICD Code J06.9, J00, R50.9, J20.9, M54.5

12. Etiology:

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

14. Plan / Details of Management

a. Procedure: CEFTRIAXONE-TABUK IV, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION, (DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION, Administered intravenously, Intramuscular injection, Blood Count Complete Auto&Auto Diffrntl Wbc Count, C-Reactive Protein, 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 families 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 code 0195-107704-0801, 2190-106618-1001, 0125-122107-1022, 96365, 96372, 85025, 86140, 9

b. Laboratory Test:

c. Radiology / Investigations:

15. In Case of Hospitalization: Date of Admission:

Date of Discharge:

16.

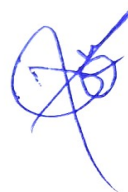
PREScription WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0027-265802-1161	(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	SYRUP (200ML, BOTTLE)	7	Take 1 Syrup 2 Time(s) per Day For 7 Day(s) after meal
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	7	Take 1 Tablets 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)	5	Take 1 Tablets 2 Time(s) per Day For 5 Day(s) after meal
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	Take 1 Tablets 1 Time(s) per Day For 5 Day(s) others

Date: 29-10-24(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: 29-10-24(dd/mm/yy)

Signature of Insured / Claimint



Copy of NGI - Pharmacy

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

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