



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:

pc: migraine 1 hour

severe headache

8. Duration of Symptoms:

9. Onset of Condition:

10. Relevant Past Medical/Surgical History

Diagnosis: Migraine w/o aura, not intractable, with status migrainosus, Pain, unspecified, Headache, unspecified

12. Etiology:

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

14. Plan / Details of Management

a. Procedure: CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION, Administered intravenously, Intramuscular injection, 9.019.01 - (9.01) - Follow Up - Consultation GP - (AED 0.0000)

b. Laboratory Test:

c. Radiology / Investigations:

15. In Case of Hospitalization: Date of Admission:

I038-000-

117549032-01

2. Authorization

Code:

RAJAA RAHOULE

15-08-84(dd/mm/yy)

☐ Male ☒ Female

Mobile No. 527336528

☐ Acute ☐ Chronic ☐ Emergency☐ Yes ☐ No

ICD Code G43.001, R52, R51.9

CPT code 0005-149902-1021, 2190-106618-1001, 96365, 96372, 9.01

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

16.

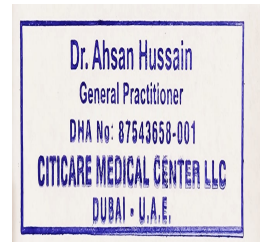
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
1162-699701-0391	(ACETYLSALICYLIC ACID : 250 MG) (CAFFEINE : 65 MG) (PARACETAMOL : 250 MG) FILM COATED TABLETS	FILM COATED TABLETS (24S, HDPE BOTTLE)	7	Take 1 Tablets 2 Time(s) per Day For 7 Day(s) others
0006-199803-1171	(SUMATRIPTAN : 100 MG) TABLETS	TABLETS (6S, BLISTER PACK)	7	Take 1 Tablets 1 Time(s) per Day For 7 Day(s) others

Date: 09-11-24(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: 09-11-24(dd/mm/yy)

Signature of Insured / Claimint



Copy of NGI - Pharmacy

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

NGI House Building, P.O. Box 154, Deira, Dubai, Tel: +971 4 211 5800, Fax: +971 4 250 2854, Email: ngico@emirates.net.ae, Website: www.ngi.ae

