eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

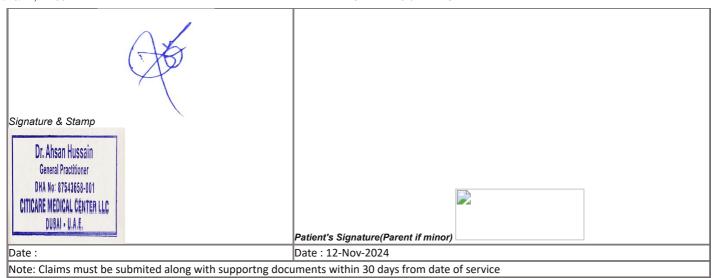
at the CITICARE MEDICAL CENTER LLC

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SUBJECTIVE ASSESSMENT

Symptom(s) a	s describe	d by the pa	atent (Chie	Complaint):			Date of	Symptoms	/illness starte	ed .
Complaint								DD	ММ	YYYY	
pc: fever 1	day										
flu 1 day											
headache	9										
sorethroat											
epigastric pain											
low back	pain										\dashv
					Ι	T T		Data of	Symptom	/illness start	ho
Past Medical Surgical History?					○Yes	○ No		DD DD	MM	үүүү	eu
											\neg
Ola - / Coma Clasia								Date of	Symptoms	/illness start	ed
Obs/Gyn Clair	ns 							DD	MM	YYYY	
☐ Para	Gravid	a:	☐ AB:	LMP:	Marital Status:	Marital Date:					
What date did	the Patient	firet fool ca	me / similar	Symptom(s	l) : dd mm yyyy						\dashv
						nt Assessment and since	. whon:				\dashv
						it Assessment and since	wiieii.				
OBJECTIVE / /		NT(To be o	completed b	y Physician)							_
Clinical Findii	ngs :				Vital S : 18	igns: B/P:100	T : 30	6.5	HR : 8	36	RR
Assessment/I	Diagnosis : DICATE DI			Chronic TOM	O Confirmed	Suspected					
Туре		Code	Dia	gnosis							
Primary		J06.9	Acı	te upper re	espiratory infection,	unspecified					
Secondary K21.9		Gas	Gastro-esophageal reflux disease without esophagitis								
Secondary		M54.5	Lov	/ back pain							
Secondary		J20.9	Acı	te bronchit	is, unspecified						

ACCIDENT/OCC	CUPATIONAL Claim II	nformaton (complete	e if claim is a re	esult of accident or wo	ork related i	llness/in	iurv)		
	ess due to work?	Injury due to road accident?		Describe how the acc		cur:			
○ Yes ○ No		○Yes(○ No						
Date of accider	nt or beginning of illr	iess:		1					
MEDICAL PLAN	Itemized Original In	voices and Applicable	e Prescriptions ,	/ Reports / Results mu	ust be enclo	sed to co	nsider claim		
CPT Code	Treatment Type Price							Price	
9	GP Consultation							25.0000	
86140	C-reactive protein;							15.0000	
85025	Blood count; comp automated differer	Lab	20.0000						
94640	Pressurized or non- induction for diagn inhaler or intermitt	Co.Pay	15.0000						
0188- 135906- 2441	PULMICORT	Pharmacy	10.4800						
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular							10.0000	
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour							40.0000	
0005- 174202- 0781	RISEK 40MG	Pharmacy	34.0000						
0125- 122107- 1022	DEXAMETHASONE INJECTION	Pharmacy	2.3400						
2190- 106618- 1001	PARAFUSIV I.V. 10M	Pharmacy	8.4000						
0005- 107704- 0802 TRIAXONE I.V(CEFTRIAXONE : 1 G) POWDER FOR INJECTION								58.5000	
Code	Generic				Duration	Instruct	Instructions		
0027-265802 1161	- (BUTAMIRATE DI					Take 1Syrup 2 Time(s) per Day For 7 Day(s) after meal			
0252-185801 0391		MINE : 25 MG) (PARA RINE : 30 MG) FILM C			7 Take 1Tablets 2Time(s) perD Day(s) after meal			erDay For 7	
0139-116206 1171	(CLAVULANIC AC	ID : 125 MG) (AMOX	G) TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others				
0195-123701 0391	- (CETIRIZINE HCL	: 10 MG) FILM COAT	ED TABLETS		7	Take 1Tablets 1 Time(s) per Day 7 Day(s) others		er Day For	
O Pharmacy:		Estmated Costs		O Laboratory / Radiology:			ated Costs		
		O Surgery:		○ Endoscopy:					
Is the following required		O Physiotherapy:		Other Procedures:					
		o i nysiotnerapy.		If yes please specify					
	quired ? Length of Sta			Indicate Provider				ate Cost	
& that the med	that all informaton i lical services shown c ated & necessary for	on this form were	to release an	horize any Healthcare ny informaton regardii ose of determining ins y of doctor and the pa	ng my medio urance bene	cal condit	on and history to	NEXtCARE	
	an Name : AHSAN H I	JSSAIN	, caponaionit)	, oj adetor ana trie pa					
Tel / Fax (import			1						



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