



1. HealthNet Policy Number

I038-000-
118933628-012.
Authorization
Code:

2. Patient Name

SHAMNAS KOTTAYIL YOUSEF YOUSEF

3. Patient Date of Birth & Sex

15-03-97(dd/mm/yy)

☒ Male ☐
Female

Mobile No. 0545479458

5. Nature of illness or Injury

☐ Acute ☐ Chronic ☐ Emergency

6. Are You the patient's primary physician

☐ Yes ☐ No

7. Presenting Complaints:

pc : sore throat , cough which is dry , fever for 3 days

nasal congestion on and off

burning micturation for 1 week

no other med conditions

no drug allergies

o/e hyperemia of throat

chest clear

8. Duration of Symptoms:

9. Onset of Condition:

10. Relevant Past Medical/Surgical History

Diagnosis: Acute pharyngitis, unspecified, Allergic rhinitis, unspecified, Fever, unspecified

ICD Code J02.9, J30.9, R50.9

12. Etiology:

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

14. Plan / Details of Management

a. Procedure: Blood Count Complete Auto & Auto Diffrntl Wbc Count, Urns Dip Stick/Tablet Reagent Auto Microscopy, 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 patient's and/or family's 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 85025, 81001, 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
0006-106601-0393	(PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (48S, BLISTER PACK)	5	Take 1Tablets 3Time(s) perDay For 5 Day(s) others
0006-104201-1161	(TRIPROLIDINE : 0.25 MG/ML) (GUAIFENESIN : 20 MG/ML) (PSEUDOEPHEDRINE : 6 MG/ML) SYRUP	SYRUP (200ML, BOTTLE)	7	Take 1Syrup 3 Time(s) per Day For 7 Day(s) others
2715-440703-0451	(FOSFOMYCIN (AS TROMETAMOL : 3000 MG GRANULES	GRANULES (1S, SACHET	3	Take 1Tablets 1 Time(s) per Day For 3 Day(s) after meal
0397-116207-0391	(AMOXICILLIN : 500 MG (CLAVULANIC ACID : 125 MG FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP	7	Take 1Tablets 2Time(s) perDay For 7 Day(s) after meal
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	7	Take 1 Unit(s), 1 Time(s) per Day For 7 Day(s)

Date: 15-01-25(dd/mm/yy)

Doctor's Name SANDIA

Signature and Stamp

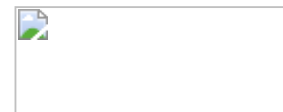



Physician Code DHA-P-65900212 HNM Code

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: 15-01-25(dd/mm/yy)

Signature of Insured / Claimint

Copy of NGI - Pharmacy

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

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