



1.HealthNet Policy Number

I038-000-
115438148-012.
Authorization
Code:

2.Patient Name

DANIEL OJONUGWA ADUKU

3.Patient Date of Birth & Sex

15-05-83(dd/mm/yy)

☒ Male ☐
Female

Mobile No.526770890

5.Nature of illness or Injury

☐ Acute ☐ Chronic ☐ Emergency

6.Are You the patient's primary physician

☐ Yes ☐ No

7.Presenting Complaints:

pc: came for evaluation of sexual health , joint pain on and off

trying to concieve

married since 5 months

bp is elevated

no problem related to sexual health

alcohol no smoking

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiHypothyroidism, unspecified, Low back pain

ICD Code E03.9, M54.5

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureBlood Count Complete Auto&Auto Difrntl Wbc Count,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 familys 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 code85025,9

b.Laboratiry Test:

c.Radiology / Investigations:

15.In Case of Hospitalization: Date of Admmission:

Date of Discharge:

16.

PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
2150-575201-1171	(CALCIUM : 400 MG (VITAMIN D3 : 200 IU (MAGNESIUM : 100 MG (ZINC : 4 MG TABLETS	TABLETS (30S, BOX	30	Take 1 Unit(s), 1 Time(s) per Day For 30 Day(s)

Date: 22-01-25(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: 22-01-25(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

