



1.HealthNet Policy Number

1038-000-117567896- 2. Authorization
01 Code:

2.Patient Name

YOUSSEF ABLOU

3.Patient Date of Birth & Sex

10-04-94(dd/mm/yy)

☒ Male ☐ Female

5.Nature of illness or Injury

Mobile No.0502963602

☐ Acute ☐ Chronic ☐ Emergency

6.Are You the patient's primary physician

☐ Yes ☐ No

7.Presenting Complaints:

c/o abdominal discomfort since yesterday

gastritis+

nausea+

dizziness because he did not have food since today morning

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevant Past Medical/Surgical History

Diagnosis: Acute gastritis with bleeding, Nausea, Dizziness and giddiness

ICD Code K29.01, R11.0, R42

12.Etiology:

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

14.Plan / Details of Management

a.Procedure: Gp Consultation, PANTONIX 40MG I.V., PREMOSAN - (METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION, 5% W/V DEXTROSE 0.45% & W/V SODIUM CHLORIDE, SICK LEAVE - 1 DHA

CPT code 9,0005-242802-0781, 0005-150403-1021, 2849-100143-0991,

b.Laboratory Test:

c.Radiology / Investigations:

15.In Case of Hospitalization: Date of Admission:

Date of Discharge:

16.

PRESCRIPTION WITH DOSAGE & DURATION

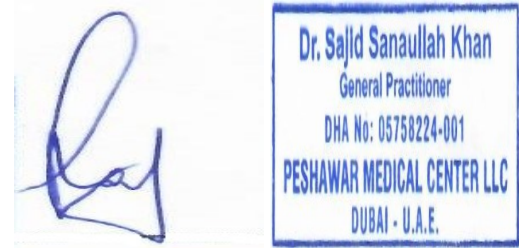
Code	Generic	Dosage	Duration	Instructions
2321-378103-1171	(METOCLOPRAMIDE HCL : 10 MG) TABLETS	TABLETS (10S, BLISTER PACK)	5	Take 1 Tablets 1 Time(s) per Day For 5 Day(s) after meal
0031-168201-0391	(DOMPERIDONE : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (30S, BLISTER PACK)	5	Take 1 Tablets 3 Time(s) per Day For 5 Day(s) after meal
2104-242802-0341	(PANTOPRAZOLE (AS SODIUM) : 40 MG) ENTERIC COATED TABLETS	ENTERIC COATED TABLETS (14S, BLISTER PACK)	10	Take 1 Tablets 2 Time(s) per Day For 10 Day(s) 30 minutes before meal

Date: 20-10-23(dd/mm/yy)

Doctor's Name Sajid Sanaullah

Signature and Stamp

Physician Code DHA-P-5758224 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: 20-10-23(dd/mm/yy)

Signature of Insured / Claimint



Copy of NGI - Pharmacy

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

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