1.HealthNet Policy Number: I038-000-115438148-01 2. 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:

pain in left lower back radiating to thigh, acidity off and on

H/o Same in the past, relieved by NSAIDs and muscle relaxant

No h/o fever, urinary problem of stone

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiLow back pain, Pain, unspecified, Acute gastritis without bleeding ICD Code M54.5, R52, K29.00

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureIntramuscular injection,CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,Gp Consultation CPT code96372,0005-149902-1021,9

b.Laboratiry Test:

c.Radiology / Investigations:

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

16.

PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0137-242802-0341	(PANTOPRAZOLE (AS SODIUM) : 40 MG) ENTERIC COATED TABLETS	ENTERIC COATED TABLETS (15S, BLISTER)	15	Take 1Tablets 1 Time(s) per Day For 15 Day(s) before meal
1217-373201-2401	(TOLPERISONE : 150 MG) SUGAR COATED TABLETS	SUGAR COATED TABLETS (30S, BLISTER PACK)	15	Take 1Tablets 2 Time(s) per Day For 15 Day(s) after meal
0102-142201-0391	(DICLOFENAC POTASSIUM : 50 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	10	Take 1Tablets 2 Time(s) per Day For 10 Day(s) after meal

Date: 26-10-23(dd/mm/yy)

Signature and Stamp

Doctor's Name Sajid Sanaullah

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: 26-10-23(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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

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HealthNet