## **eASOAP FORM**

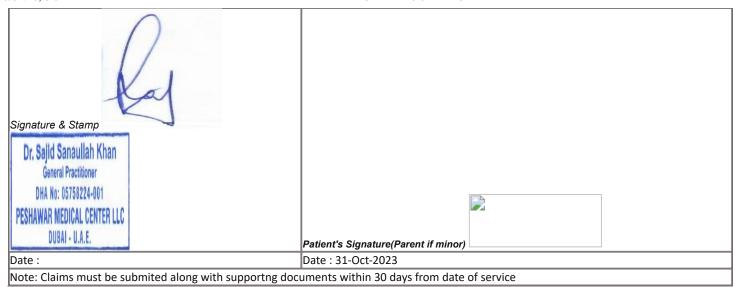


**ADMINISTRATIVE** The member is allowed for Out Patient at the Irham Medical Center Arjan Patent Name: NGUYEN THI THANH MAI Gender: **Female** Validity Between: 13/02/2023 and 12/02/2024 **Coverage Informaton** 6/8/1983 12:00:00 Card No: 704A-8C73-1505-39E5 DOB: **Out Patient** AM RN UAE (Al Ansari-AUH)-Pin #: Identty Card: Network: **MEDGULF** Natonal ID: 784-1983-7061515-9 Service Date: 31-Oct-2023 Radiology: Covered Patent's Tel No: 0556216359 Threshold Policy Holder: Limit: **ORIENT INSURANCE** Normal Payer Name: Class: P.J.S.C Out-Patent: Patent's File 39318 **Category B** Pharmacy: Co-Part: 20% Category: No: Gatekeeper: Nο Consultation: Laboratory: Covered Referral No: Referred Service: SUBJECTIVE ASSESSMENT Symptom(s) as described by the patent (Chief Complaint): Date of Symptoms/illness started DD MM YYYY Complaint severe cough since two weeks ago started 15/10/2023 severe wheezing since yesterday Date of Symptoms/illness started O No ○ Yes Past Medical Surgical History? MM YYYY Date of Symptoms/illness started Obs/Gyn Claims DО MM YYYY ☐ Para ☐ AB: LMP: Marital Status: Marital Date: ☐ Gravida: What date did the Patient first feel same / similar Symptom(s) : dd mm yyyy ls the Patient under any type of Treatment? O Yes O No if yes, indicate what Assessment and since when: OBJECTIVE / ASSESSMENT(To be completed by Physician)

Clinical Findings :			Vital Signs : B/P : 112 : 22	T : 36.8	HR : 82	RR				
Assessment/Diagnosis : Chronic Confirmed Suspected INDICATE DIAGNOSIS NOT SYMPTOM										
Туре	Code		Diagnosis							
Primary	J20.9		Acute bronchitis, unspecified							
Secondary	J01.40		Acute pansinusitis, unspecified							
Secondary	R06.2		Wheezing							

ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

I// CCIDENT OF IIINGSS DITE TO WIOTE?			Injury due accident?	to road	Describe how the accident or work related injury/illness occu				ur:		
○ Yes ○ No			O Yes	) No							
Date of accident or beginning of illness:											
MEDICAL PLAN Ite	mized Original In	voices and	Applicable	Prescriptions ,	/ Reports /	Results mu	st be enclosed	l to co	onsider claim		
CPT Code	Treatment								Туре	Price	
9	GP Consultation								General Consultation	25.0000	
0188-135906- 2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION								Pharmacy	10.4800	
0006-124513- 2071	VENTOLIN NEBULES								General Consultation	1.2300	
94664	Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device								Co.Pay	20.0000	
0102-100104- 1001	SODIUM CHLORIDE & DEXTROSE B.P.								Pharmacy	4.5000	
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour								Co.Pay	40.0000	
0005-111805- 1021	CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION								Pharmacy	1.2000	
0125-122107- 1022	DEXAMETHASONE SODIUM PHOSPHATE								Pharmacy	2.3400	
0195-107704- 0801	CEFTRIAXONE-TABUK IV								Pharmacy	48.5000	
						<u> </u>					
Code	Generic					Duration	Instructions				
0006-402804- 2481	(SALBUTAMOL(AS SULPHATE) : 2 MG/5ML) SYRUF FREE)				P (SUGAR	7	Take 5ML 3 T	3 Time(s) per Day For 7 Day(s) others			
0015-101502- 0271	(ACETYLCYST	ETS	10	Take 1Tablets others	s 1 Time(s) per Day For 10 Day(s)						
0139-116206- 1171	MG) (AMC	OXICILLIN: 875	5 MG)	7 Take 1Tablets others			2 Time(s) per Day For 7 Day(s)				
O Pharmacy:		Estmated (	Estmated Costs			C Laboratory / Radiology:			Estmated Costs		
		Surger	urgery:			○ Endoscopy:					
			siotherapy:		Other Procedures:			1			
		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			If yes please specify			1			
	101 # 101										
Is In-patient Require I hereby certfy tha			ire correct	I hereby auth	Indicate F		Provider Insura	or Fm	Estimate aployer or other Orgo		
& that the medical	•			1 '	•				and history to NEXt		
medically indicated	d & necessary for	the manag	ement of	the purpose of	of determin	ning insuran	ce benefts. Me		management is the		
this case.	Name			responsibility	of doctor	and the pat	ent.				
Treating Physician Note: Tel / Fax (important)		aulian									
Torr tax (important)	<i>)</i> -										



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