eASOAP FORM



ADMINISTRATIVE The member is allowed for **Out Patient** at the Irham Medical Center Arjan Patent Name: **ODAI AHMAD KHALIL** Gender: Validity Between: 09/02/2023 and 08/02/2024 Male **Coverage Informaton** 7/26/1999 12:00:00 Card No: 2175-8697-4AD4-032F DOB: **Out Patient** AM RN UAE (Al Ansari-AUH)-Pin #: Network: Identty Card: **MEDGULF** Natonal ID: 784-1999-1527900-6 Service Date: 13-Nov-2023 Radiology: Covered Patent's Tel No: 0509952621 Threshold Policy Holder: Limit: **ORIENT INSURANCE** Normal Payer Name: Class: P.J.S.C Out-Patent: Patent's File **Category B** 41410 Pharmacy: Co-Part: 20% Category: No: Gatekeeper: No 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 respiratory distress and severe wheezing and cough have increased severe cough and wheezing since 5/11/2023 Date of Symptoms/illness started ○ Yes O No Past Medical Surgical History? DD MM YYYY Date of Symptoms/illness started Obs/Gyn Claims DD MM YYYY ☐ AB: LMP: Marital Status: Marital Date: □ Para ☐ Gravida: What date did the Patient first feel same / similar Symptom(s): dd mm yyyy Is the Patient under any type of Treatment? \bigcirc Yes \bigcirc No $\,$ if yes, indicate what Assessment and since when: OBJECTIVE / ASSESSMENT(To be completed by Physician) Clinical Findings: Vital Signs: B/P:120 T:36.8 HR: 82 RR O Acute ○ Chronic O Confirmed Assessment/Diagnosis: ○ Suspected

Injury due to road	ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)										
Accident or illness due to work? Describe how the accident or work related injury/illness occur: Describe how the accident or work related injury/illness occur:	Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:								

Bronchopneumonia, unspecified organism

INDICATE DIAGNOSIS NOT SYMPTOM

Code

J18.0

R06.2

R05

Diagnosis

Wheezing

Cough

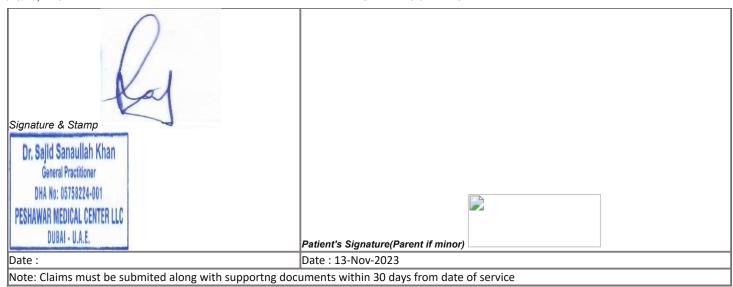
Type

Primary

Secondary

Secondary

○ Yes ○ No		○ Yes ○	No No							
Date of accident of	or beginning of illn	iess:								
MEDICAL PLAN It	emized Original In	voices and A	Applicable	Prescriptions /	Reports / Results mu	st be enclos	ed to	consider claim		
CPT Code	Treatment							Туре	Price	
9.02	9.02 - (9.02) - Follow-up consultation - (AED 0.0000)							General Consultation	0.0000	
0188-135906- 2441	PULMICORT							Pharmacy	10.4800	
0006-124513- 2071	VENTOLIN NEBULES							Pharmacy	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	
86140	C-reactive Protein							Lab	15.0000	
85651	Sedimentation	rate, erythro		Lab	10.0000					
85027	Blood count; co		Lab	15.0000						
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							Pharmacy	1.2000	
0195-107704- 0801	CEFTRIAXONE-TABUK IV							Pharmacy	48.5000	
0125-122107- 1022	DEXAMETHASONE SODIUM PHOSPHATE							Pharmacy	2.3400	
0102-100104- 1001	SODIUM CHLORIDE & DEXTROSE B.P.							Pharmacy	4.5000	
Code	Generic Duration Ins							nstructions		
1401-395404- 0391	(MONTELUKAST (AS SODIUM) : 10 MG) FILM COATED TABLETS					15	Take 1Tablets 1 Time(s) per Day For 15 Day(s) others			
0015-101502- 0271	(ACETYLCYSTEINE : 600 MG) EFFERVESCENT TABLETS 10						Take 1Tablets 1 Time(s) per Day For 10 Day(s) others			
0030-183202- 0391	(FEXOFENADINE	HCL : 180 N	1G) FILM C	OATED TABLET				Take 1Tablets 2 Time(s) per Day For 8 Day(s) others		
1393-412002- 1392	(FLUTICASONE PROPIONATE : 250 MCG/DOSE) (SALMETEROL (AS XINAFOATE) : 25 MCG/DOSE) AEROSOL INHALER					10	Take 2Puff 4 Time(s) per Day For 10 Day(s) others			
O Pharmacy:	Pharmacy: Estmated Costs			C Laboratory / Radiology:			Est	Estmated Costs		
		O Surgery:		○ Endoscopy:						
		OPhysiot	O Physiotherapy:		Other Procedures:					
					If yes please specify					
la la nationt Danvi	and Oil amounth of Otan				Indicate Provider			Cation	nate Cost	
	red ? Length of Stay at all informaton r		re correct	I hereby auth	orize any Healthcare F	Provider, Insi	urer, Ei			
& that the medica	al services shown c ed & necessary for	on this form	were	release any ir	nformaton regarding n of determining insuran	ny medical c	condito	on and history to Ni	EXtCARE for	
this case.					of doctor and the pat					
Freating Physician Name : Sajid Sanaullah										
Tel / Fax (importan	t):									



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