



1. HealthNet Policy Number

I038-000-
115297991-012.
Authorization
Code:

2. Patient Name

Mohamed Mahmoud Mohamed Khafagy

3. Patient Date of Birth & Sex

09-09-89(dd/mm/yy)

☒ Male ☐
Female

Mobile No. 0507784520

5. Nature of illness or Injury

☐ Acute ☐ Chronic ☐ Emergency

6. Are You the patient's primary physician

☐ Yes ☐ No

7. Presenting Complaints: severe left foot twitching when riding on bus today no symptom of fracture today 16/11/2023

8. Duration of Symptoms:

9. Onset of Condition:

10. Relevant Past Medical/Surgical History

Diagnosis: Pain in left ankle and joints of left foot, Inj oth muscles and tendons at ank/ft level, left foot, init

ICD Code M25.572, S96.892A

12. Etiology:

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

14. Plan / Details of Management

a. Procedure DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION, Intramuscular injection, NON-SURGICAL CLEANSING WITH SURGICAL DRESSING MORE THAN 48 SQ INCHES / 300 SQ CENTIMETERS., Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A CPT code 0125-122107-1022,0005-149902-1021,96372,51.03,9 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 families 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.

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
7070-149919-0431	(DICLOFENAC SODIUM : 1 G/100G) GEL	GEL (100G, TUBE)	4	Take 1Gel 3 Time(s) per Day For 4 Day(s) others
4179-711202-0391	(IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM COATED TABLETS	FILM COATED TABLETS (12S, BLISTER)	6	Take 1Tablets 4 Time(s) per Day For 6 Day(s) others

Date: 16-11-23(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: 16-11-23(dd/mm/yy)

Signature of Insured / Claimant



Copy of NGI - Pharmacy

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

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