1.HealthNet Policy Number I038-000-115298209-01 2. Authorization Code:

2.Patient Name Sobish Pullarathara Balan

3.Patient Date of Birth & Sex 16-05-86(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0509803581

5.Nature of illness or Injury ☐ Acute ☐ Chronic ☐ Emergency

6.Are You the patient's primary physician ☐ Yes ☐ No

7.Presenting Complaints:from 3 days ago 27/11/2023 has fever and cough and body pain

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiAcute pharyngitis, unspecified, Acute bronchitis, unspecified ICD Code J02.9, J20.9

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureFree follow-up consultation of the same diagnosis within 7 days of initial consultation by a General Practitioner.,(SALBUTAMOL : 5 MG/2.5ML) NEBULIZING SOLUTION,nebulization with ventoline solution,(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,Intramuscular injection CPT code9.1,0006-124513-2071,94640,0125-122107-1021,0195-107704-0801,96372

b.Laboratiry Test:

c.Radiology / Investigations:

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

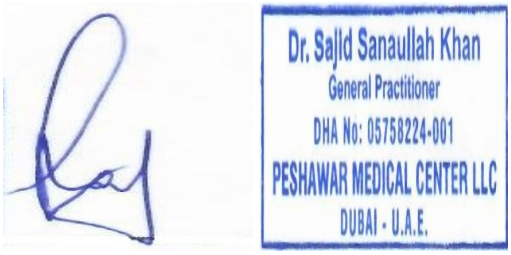
16.

PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0252-107001-1171	(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) TABLETS	TABLETS (20S, BLISTER PACK)	10	Take 1Tablets 2 Time(s) per Day For 10 Day(s) others
0045-168101-1171	(DIPHENHYDRAMINE : 30 MG) (CAFFEINE : 7.5 MG) (EPHEDRINE : 7.5 MG) (PARACETAMOL : 300 MG) TABLETS	TABLETS (20S, BOX)	10	Take 1Tablets 2 Time(s) per Day For 10 Day(s) others
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others

Date: 30-11-23(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: 30-11-23(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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

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