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| <p>1. HealthNet Policy Number</p> <p>2. Patient Name</p> <p>3. Patient Date of Birth &amp; Sex</p> <p>5. Nature of illness or Injury</p> <p>6. Are You the patient's primary physician</p> <p>7. Presenting Complaints: pain in nasopharynx</p> <p>8. Duration of Symptoms:</p> <p>9. Onset of Condition:</p> <p>10. Relevant Past Medical/Surgical History</p> <p>Diagnosis: Acute sinusitis, unspecified, Fever, unspecified, Pain, unspecified</p> <p>12. Etiology:</p> <p>13. In case of Injury: mode of Injury/place of Injury</p> <p>14. Plan / Details of Management</p> <p>a. Procedure: Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A 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 patient's and/or family's 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., (DEXTROSE : 100 MG/ML) (SODIUM CHLORIDE : 1.8 MG/ML) SOLUTION FOR INFUSION, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION, Administered intravenously, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION, (CEFTRIAXONE (AS SODIUM) : 500 MG) POWDER FOR INJECTION, Intramuscular injection, Blood Count Complete Auto&amp;Auto Diffrntl Wbc Count, Creatinine Blood, Sedimentation Rate Rbc Automated, C-Reactive Protein</p> <p>b. Laboratory Test:</p> <p>c. Radiology / Investigations:</p> | <p>2. Authorization Code:</p> <p>THU ZAR HUN</p> <p>12-07-91(dd/mm/yy) <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female</p> <p>Mobile No. 0582321476</p> <p><input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> Emergency</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>ICD Code J01.90, R50.9, R52</p> <p>CPT code 9, 0442-100132-1003, 2190-106618-1001, 96365, 0005-111805-1021, 0067-107702-0801, 96372, 85025, 82565, 85652, 86140</p> <p>Date of Discharge:</p> |
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15. In Case of Hospitalization: Date of Admission:

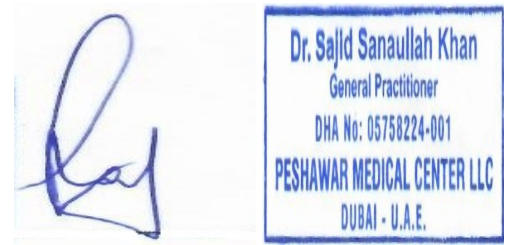
16. PRESCRIPTION WITH DOSAGE & DURATION

| Code             | Generic                                                                                    | Dosage                                      | Duration | Instructions                                          |
|------------------|--------------------------------------------------------------------------------------------|---------------------------------------------|----------|-------------------------------------------------------|
| 0788-106705-1171 | (CHLORPHENIRAMINE MALEATE : 2 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) TABLETS | TABLETS (24S, BLISTER PACK)                 | 10       | Take 1 Tablets 3 Time(s) per Day For 10 Day(s) others |
| 0015-101502-0271 | (ACETYLCYSTEINE : 600 MG) EFFERVESCENT TABLETS                                             | EFFERVESCENT TABLETS (10S, TUBE)            | 10       | Take 1 Tablets 1 Time(s) per Day For 10 Day(s) others |
| 0027-265802-1161 | (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP                                          | SYRUP (200ML, BOTTLE)                       | 5        | Take 8ML 3 Time(s) per Day For 5 Day(s) others        |
| 1307-127402-1451 | (AZITHROMYCIN : 250 MG) CAPSULES (HARD GELATIN)                                            | CAPSULES (HARD GELATIN) (6S, BLISTER PACK)  | 6        | Take 1 Tablets 2 Time(s) per Day For 6 Day(s) others  |
| 4342-273401-1452 | (OSELTAMIVIR (AS PHOSPHATE) : 75 MG) CAPSULES (HARD GELATIN)                               | CAPSULES (HARD GELATIN) (10S, BLISTER PACK) | 5        | Take 1 Tablets 2 Time(s) per Day For 5 Day(s) others  |

Date: 17-12-23(dd/mm/yy)

Doctor's Name Sajid Sanaullah

Signature and Stamp



Physician Code DHA-P-5758224 HNM Code

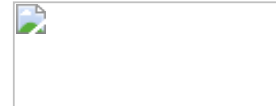
**Authorization**

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: 17-12-23(dd/mm/yy)

Signature of Insured / Claimant



Copy of NGI - Pharmacy

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

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