

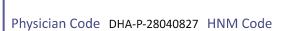
1.HealthNet Policy Number	1038-000- 120193922-01	2. Authorization Code:	
2.Patient Name	AMJIDEEN MOHAMED ANAS MOHAMED		
3.Patient Date of Birth & Sex	06-07-99(dd/mr	n/yy)	
	Mobile No.971552184788		
5.Nature of illness or Injury	☐ Acute ☐ Chronic ☐ Emergency		
6. Are You the patient's primary physician	☐ Yes ☐ No		
7.Presenting Complaints:			
C/o: Pain on the right thumb			
Said to have started this morning suddenly while playing cricket game.			
Mild swelling but there is no obvious deformity and there is no limitation of move	ment.		
8.Duration of Symptoms:			
9.Onset of Condition:			
10.Relevent Past Medical/Surfgical History			
DiagonosisiOther sprain of right thumb, initial encounter, Acute pain due to trauma	ICD Code S63.68	31A, G89.11	
12.Etiology:			
13.In case of Injury:mode of Injury/place of Injury			
14.Plan / Details of Management			
a.ProcedureOffice 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 patients and/or familys 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.,Intramuscular injection,CLOFEN	CPT code9,9637	72,0005-149902-1021	
b.Laboratiry Test:			
c.Radiology / Investigations:			
15.In Case of Hospitalization: Date of Addmission:	Date of Dischar	ge:	
16			

16.	

PRESCRIPTION WITH DOSAGE & DURATION						
Code	Generic	Dosage	Duration	Instructions		
2093-596002- 0431	(DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL	GEL (50G, TUBE)	14	Take 1Cream 3 Time(s) per Day For 14 Day(s) others		
0027-149907- 0111	(DICLOFENAC SODIUM : 75 MG) COATED TABLETS	COATED TABLETS (10S, BLISTER PACK)	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal		

Date: 25-12-23(dd/mm/yy)

Doctor's Name Enomen Goodluck Signature and Stamp





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

25-12-23(dd/mm/yy) Signature of Insued / Claimint Date:

Copy of NGI - Pharmacy

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



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