1.HealthNet Policy Number	I038-000-117931761-01 2. Authorization Code:
2.Patient Name	MERIEM AGOUNDIS
3.Patient Date of Birth & Sex	19-10-01(dd/mm/yy) ☐ Male ☑ Female
	Mobile No.0563224278
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 passing urine, since yesterday.

Also pain in throat, generalized body pains, blocked nostrils, weakness and high grade fever.

Does not have any significant past medical history,

Not hypertensive and not diabetic. Not asthmatic.

8.Duration of Symptoms:2 DAYS

9.Onset of Condition:16/1/2024

10.Relevent Past Medical/Surfgical HistoryNIL

DiagonosisiAcute pharyngitis due to other specified organisms, Acute nasopharyngitis [common cold], Urinary tract infection, site not specified, Fever presenting with conditions classified elsewhere, Acute ethmoidal sinusitis, unspecified, Allergic rhinitis, unspecified, Pain, unspecified	ICD Code J02.8, J00, N39.0, R50.81, J01.20, J30.9, R52
12.Etiology:Pain on passing urine	
13.In case of Injury:mode of Injury/place of Injury	NIL

14.Plan / Details of Management

a.ProcedureBlood Count Complete Auto&Auto Difrntl Wbc Count,C-Reactive Protein,Sedimentation Rate Rbc Automated,Intravenous Injection,CEFTRIAXONE-TABUK IV,CLOFEN ,DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,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 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.	CPT code85025,86140,85652,96374,0195-107704-0801,0005-149902-1021,0125-122107-1022,9
b.Laboratiry Test:	CRP-CBC-ESR
c.Radiology / Investigations:	
15.In Case of Hospitalization: Date of Addmission:	Date of Discharge:

16.

PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0252-182201-0081	(FOLIC ACID : 0.35 MG) (IRON (AS FERRIC/FERROUS HYDROXIDE POLYMALTOSE COMPLEX) : 100 MG) CHEWABLE TABLETS	CHEWABLE TABLETS (30S, BLISTER PACK)	60	Take 1Tablets 1 Time(s) per Day

Code	Generic	Dosage	Duration	Instructions
				For 60 Day(s) others
1233-402701-1171	(PANTOTHENIC ACID (VITAMIN B5) : 6 MG) (PHOSPHORUS : 125 MG) (CHOLECALCIFEROL : 400 IU) (RIBOFLAVINE (VITAMIN B2) : 1.6 MG) (BIOTIN : 100 MCG) (FOLIC ACID : 195 MCG) (THIAMINE (VITAMIN B1) : 1.4 MG) (PHYTONADIONE (VITAMIN K1) : 30 MCG) (PYRIDOXINE (VITAMIN B6) : 2 MG) (ASCORBIC ACID (VITAMIN C) : 60 MG) (VITAMIN A : 4000 IU) (VITAMIN E : 14.9 IU) (LUTEIN : 1000 MCG) (MOLYBDENUM : 50 MCG) (IRON (FERROUS FUMARATE) : 10 MG) (NIACINAMIDE : 18 MG) (VITAMIN B12 : 1 MCG) (SELENIUM (AS SODIUM SELENATE)	TABLETS (30S, PLASTIC BOTTLE)	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) evening
0214-125801-1952	(POVIDONE IODINE : 1 G/100ML) LIQUID FOR MOUTHWASH	LIQUID FOR MOUTHWASH (135ML, BOTTLE)	7	Take 1Solution 6 Time(s) per Day For 7 Day(s) others
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	10	Take 1Tablets 1 Time(s) per Day For 10 Day(s) after meal
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	7	Take 1Tablets 2Time(s) perDay For 7 Day(s) after meal
0252-185801-0391	(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	10	Take 1Tablets 2 Time(s) per Day For 10 Day(s) after meal
0027-142201-0831	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	POWDER FOR SOLUTION (30S, SACHET)	5	Take 1sachet 3 Time(s) per Day For 5 Day(s) after meal

Date: 17-01-24(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: 17-01-24(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

NATIONAL GENERAL INSURANCE CO. (P.J.S.C)
NGI House Building, P.O. Box 154, Deira, Dubai, Tel: +971 4 211 5800, Fax: +971 4 250 2854, Email: ngico@emirates.net.ae, Website: www.ngi.ae

HealthNet