



1.HealthNet Policy Number

2.Patient Name

3.Patient Date of Birth & Sex

5.Nature of illness or Injury

6.Are You the patient's primary physician

7.Presenting Complaints:

I038-000-118933627-01

MOUNIR BENDAD

23-01-84(dd/mm/yy)

Mobile No.0522213325

☐ Acute

☐ Chronic

☐ Emergency

☐ Yes

☐ No

2.Authorization Code:

☒ Male

☐ Female

C/O DRY COUGH,FEVER,SORE THROAT,MOUTH ULCERS AND BODY PAIN SINCE 3 DAYS

O/E PATIENT HAS HYPREMIC THROAT AND CHEST CONGESTION

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevant Past Medical/Surgical History

DiagnosisAcute upper respiratory infection, unspecified, Cough, Fever, unspecified, Acute pharyngitis, unspecified, Pain, unspecified, Oral mucositis (ulcerative), unspecified

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 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.,(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,CHLORHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,Administered intravenously,therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure) - (AED 11.0000),Blood Count Complete Auto&Auto Diffrntl Wbc Count,C-Reactive Protein,(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure) - (AED 11.0000)

b.Laboratory Test:

c.Radiology / Investigations:

15.In Case of Hospitalization: Date of Admission:

Date of Discharge:

16.

PRESCRIPTION WITH DOSAGE & DURATION

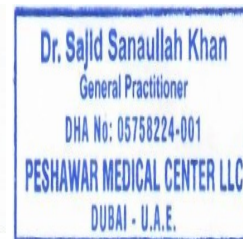
Code	Generic	Dosage	Duration	Instructions
1144-253101-1162	(HEDERA HELIX (IVY) : 7MG/ML) SYRUP	SYRUP (200ML, GLASS BOTTLE)	7	Take 1Syrup 3 Time(s) per Day For 7 Day(s) others
2006-552301-0431	(SYMPLOCOS RACEMOSA (LODHRA) : 3 MG/1G) (RASANA : 1.6 MG/1G) (TAGAR : 3.2 MG/1G) (KUSHTHA : 4.8 MG/1G) (IRIMED : 134 MG/1G) (KHADIR : 134 MG/1G) (KARPOOR : 1 MG/1G) (YASTIMADHU : 40 MG/1G) (SHARKARA : 150 MG/1G)	GEL (10G, ALUMINIUM TUBE)	7	Take 1Gel 1 Time(s) per Day For 7 Day(s) others

Code	Generic	Dosage	Duration	Instructions
	(CAFFEINE ANHYDROUS : 1.5 MG/1G) (COOL MINT : 25.04 MG/1G) GEL			
0005-101701-0392	(ACECLOFENAC : 100 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER)	5	Take 1Tablets 3 Time(s) per Day For 5 Day(s) others
0006-106601-0392	(PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (96S, BLISTER PACK)	5	Take 2Tablets 3 Time(s) per Day For 5 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: 04-02-24(dd/mm/yy)

Doctor's Name Sajid Sanaullah

Signature and Stamp

Physician Code DHA-P-5758224 HNM Code

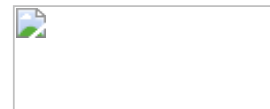
Authorization

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: 04-02-24(dd/mm/yy)

Signature of Insured / Claimant



Copy of NGI - Pharmacy

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

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