## **eASOAP FORM**



**ADMINISTRATIVE** The member is allowed for Out Patient at the Irham Medical Center Arjan **TAALIAH JAVAID LONE** Patent Name: Gender: **Female** Validity Between: 04/10/2023 and 06/09/2024 JAVAID IQBAL LONE **Coverage Information** 10/22/2000 12:00:00 Card No: 9863-EBE2-4F59-8EB8 DOB: **Out Patient** AM RN UAE (Al Ansari-AUH)-Pin #: Identty Card: Network: **MEDGULF** 784-2000-1848180-2 24-Feb-2024 Natonal ID: Service Date: Radiology: Covered Patent's Tel No: 0524395589 Threshold Policy Holder: Limit: **ORIENT INSURANCE** Payer Name: Class: Normal P.J.S.C Out-Patent: Patent's File **Category B** 38230 Pharmacy: Co-Part: 20% Category: No: Gatekeeper: Consultation: Laboratory: Covered No Referral No: Referred Service:

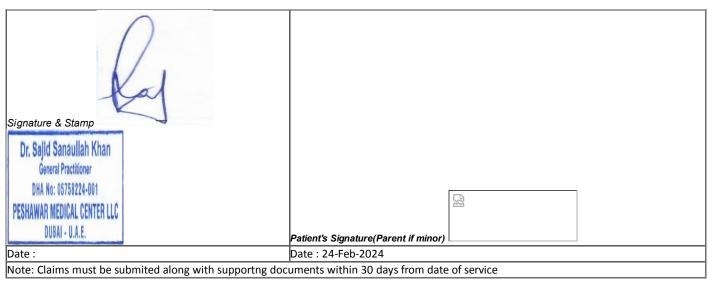
## SUBJECTIVE ASSESSMENT

symptom(s)	as described by the	Date o	Date of Symptoms/illness started						
Complaint		DD	MM	YYYY					
C/o: Genera transiently b	lized body pains, hea by pcm.								
Also has nas	sal congestion and na								
Has PCOD, b	out has no other sign	ificant medic	al history,	not hypertensive and	d not diabetic.				
Past Medical Surgical History?			O Yes	O No	Date o	Date of Symptoms/illness starte			
				O res	TO NO	DD	MM	YYYY	
Nha/Con Clair		Date o	Date of Symptoms/illness started						
bs/Gyn Clair	ms	DD	MM	YYYY					
Para	Gravida:	AB:	LMP:	Marital Status:	Marital Date:				
	the Patient first feel sa	me / similar 9	Symptom(s)	· dd mm yyyy					
					at Assessment and since	when:			
	ASSESSMENT(To be			700,					
Clinical Findi	•	completed by	Tilysician	Vital Signs: B/P:110 T: RR:22			36.9 HR: 87		
ssessment/ IN	Diagnosis : O A IDICATE DIAGNOSIS		Chronic OM	O Confirmed	O Suspected				
Туре Code			Diagnosis						
Primary J02.9			Acute pharyngitis	, unspecified					
1 Illian y									
Secondary		J03.90		Acute tonsillitis, u	inspecified				

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Туре		Code	Diag	Diagnosis						
Secondary		R50.9	Feve	Fever, unspecified						
ACCIDENT/OCCUPATION	ONAL Claim	Informaton (con	nplete if clair	n is a	result of accident or wor	k related illi	ness/inj	jury)		
Accident or illness due to work?				ury due road Describe how the accident or work related injury/illness occur: cident?						
O Yes O No			No No	Yes C	)					
Date of accident or be	ginning of ill	lness:			1					
/IEDICAL PLAN Itemize	ed Original I	nvoices and Appl	licable Prescr	iption	s / Reports / Results must	be enclose	d to co	nsider claim		
CPT Code	Treatment							Туре	Price	
96375	Therapeut additional addition to	Co.Pay	5.0000							
0005-111805-1021	CHLOROHI	STOL 10MG						Pharmacy	1.2000	
0005-149902-1021	CLOFEN	Pharmacy	6.5000							
0125-122107-1022	DEXAMETI INJECTION	Pharmacy	2.3400							
0195-107704-0801	CEFTRIAXC	NE-TABUK IV	Pharmacy	48.5000						
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour							Co.Pay	40.0000	
9 CONSULTATION GP								General Consultation	25.000	
Code	Generic	Generic Duration Instructions						ctions		
4874-125821-3801	(POVIDON		7	Take 1Spray 1Time(s) perDay For 7 Day(s) after meal						
1516-107902-1171	(IBUPROFE	:N : 400 MG) TAE	BLETS					Take 1Tablets 3 Time(s) per Day For 5 Day(s) after meal		
1204-571401-1161	•	•	, ,	EUDOEPHEDRINE HCL : 30 5 MG/5ML) SYRUP			Take 10ML 3 Time(s) per Day For 7 Day(s) after meal			
0195-123701-0391	(CETIRIZIN	E HCL : 10 MG) F	ILM COATED	ATED TABLETS			Take 1Tablets 1 Time(s) per Day For 10 Day(s) after meal			
0252-185801-0391				RACETAMOL : 500 MG) M COATED TABLETS			Take 1Tablets 2 Time(s) per Day For 10 Day(s) after meal			
O Pharmacy:		Estmated Costs O Laboratory / Radiology: Es				Estma	ated Costs			
		-	O Surgery:		Endoscopy:					
s the following required			O Physiothera		Other Procedures:					
				lf y	es please specify					
In-patient Required ?	Length of Sta	ау			Indicate Provider			Estima	ate Cost	
hereby certfy that all that the medical ser redically indicated & nis case.	vices shown necessary fo	on this form we or the managem	re to rel ent of for th	ease d e purp	thorize any Healthcare Pi Iny informaton regarding Dose of determining insur Ity of doctor and the pate	my medica ance benef	ıl condi	ton and history to	NEXtCAR	
reating Physician Nam	e : Sajid Sar	naullah								
el / Fax (important):										

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