1.HealthNet Policy Number	I038-000-115298135-01
2. Authorization Code:	
2.Patient Name	IKECHUKWU VICTOR NDUCHE
3.Patient Date of Birth & Sex	13-09-85(dd/mm/yy) ☑ Male ☐ Female
	Mobile No.0555891985
5.Nature of illness or Injury	☐ Acute ☐ Chronic ☐ Emergency
6.Are You the patient's primary physician	☐ Yes ☐ No

7.Presenting Complaints:

C/o: Upper burning abdominal pain since 2 weeks.

Also diarrhea with 3 episodes today.

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiAcute gastritis without bleeding, Gastro-esophageal reflux dis with esophagitis, without bleed, Diarrhea, unspecified	ICD Code K29.00, K21.00, R19.7

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	CPT code9

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.

b.Laboratiry Test:

c.Radiology / Investigations:

15.In Case of Hospitalization: Date of Addmission: Date of Discharge:

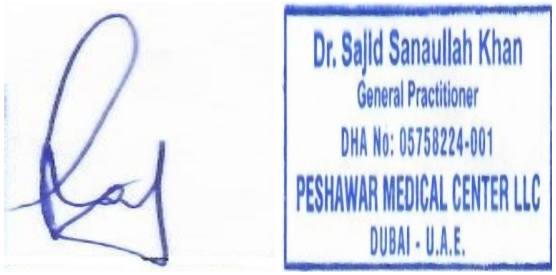
16.

PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0005-141604-0081	(ALUMINIUM HYDROXIDE : 200 MG) (MAGNESIUM HYDROXIDE : 200 MG) (SIMETHICONE : 25 MG) CHEWABLE TABLETS	CHEWABLE TABLETS (30S, BLISTER PACK)	5	Take 1Tablets 6 Time(s) per Day For 5 Day(s) others
1614-530501-0611	(DEXLANSOPRAZOLE : 60 MG) MODIFIED RELEASE CAPSULES	MODIFIED RELEASE CAPSULES (28S, BLISTER PACK)	28	Take 1Tablets 1 Time(s) per Day For 28 Day(s) before meal

Date: 26-02-24(dd/mm/yy)

Signature and Stamp



Doctor's Name Sajid Sanaullah

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: 26-02-24(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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