| | | | |
|---|---|---|---|
| 1.HealthNet Policy Number | I038-000-119995796-01 | 2. Authorization Code: | |
| 2.Patient Name | EMELIE SABLAYAN DELA CRUZ | | |
| 3.Patient Date of Birth & Sex | 20-01-74(dd/mm/yy) | ☐ Male ☑ Female | |
| | Mobile No.0585202276 | | |
| 5.Nature of illness or Injury | ☐ Acute ☐ Chronic ☐ Emergency | | |
| 6.Are You the patient's primary physician | ☐ Yes ☐ No | | |

7.Presenting Complaints:

c/o dry cough,sore throat ,body pain ,headache and feeling of cold since 3 days

no known medicine allergies

on examination pt has inflammed tonsils with white exudates

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

| | |
|---|---|
| DiagonosisiAcute tonsillitis, unspecified, Pain, unspecified, Fever, unspecified, Cough | ICD Code J03.90, R52, R50.9, R05 |

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.,Blood Count Complete Auto&Auto Difrntl Wbc Count,C-Reactive Protein,Iaad Eia Streptococcus Group A,PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION, (DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION,(CEFTRIAXONE | CPT code | 9,85025,86140,87430,2190-106618-1001,0125-122107-1022,0005-111805-1021,0195-107704-0802,96365,96374 |

: 1 G) POWDER FOR INJECTION,Administered intravenously,Intravenous Injection

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 |
|---|---|---|---|---|
| 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 |
| 0005-116801-1162 | (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP | SYRUP (5ML X 20, SACHET) | 7 | Take 15Units 1 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) | 7 | Take 1Tablets 1 Time(s) per Day For 7 Day(s) others |
| 0005-119805-1172 | (PREDNISOLONE : 5 MG) TABLETS | TABLETS (20S, BLISTER PACK) | 5 | Take 1Tablets 2 Time(s) per Day For 5 Day(s) others |
| 0139-116207-1171 | (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS | TABLETS (20S, BLISTER PACK) | 5 | Take 1Tablets 3 Time(s) per Day For 5 Day(s) others |

Date: 07-03-24(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: 07-03-24(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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HealthNet