1.HealthNet Policy Number	I038-000-118061502-01	2. Authorization Code:
2.Patient Name	DELIA TESORO REPILLO	
3.Patient Date of Birth & Sex	13-01-76(dd/mm/yy)	☐ Male ☑ Female
	Mobile No.0582451975	
5.Nature of illness or Injury	☐ Acute ☐ Chronic ☐ Emergency	
6.Are You the patient's primary physician	☐ Yes ☐ No	

7.Presenting Complaints:

C/o: Swelling on the lower eye lid of the left eye.

since one week

There is also itching.

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiHordeolum externum unspecified eye, unspecified eyelid, Other mucopurulent conjunctivitis, left eye, Allergic rhinitis, unspecified	ICD Code H00.019, H10.022, J30.9

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:

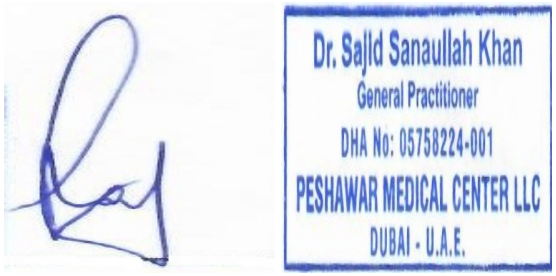
16.

PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
2027-560101-0392	(IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (16S, BLISTER)	5	Take 1Tablets 2Time(s) perDay For 5 Day(s) after meal
0195-143602-0391	(CEFUROXIME : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (14S, STRIP)	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others
0085-103204-0371	(CIPROFLOXACIN : 0.3%) EYE DROPS	EYE DROPS (5ML, DROPPER BOTTLE)	7	Take 2Drops 4 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 1Time(s) perDay For 10 Day(s) evening

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

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

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