1.HealthNet Policy Number	I038-000-115298024-01
2. Authorization Code:	
2.Patient Name	Mohamed Sayed Hassan Mohamed
3.Patient Date of Birth & Sex	17-03-97(dd/mm/yy) ☑ Male ☐ Female
	Mobile No.509282499
5.Nature of illness or Injury	☐ Acute ☐ Chronic ☐ Emergency
6.Are You the patient's primary physician	☐ Yes ☐ No

7.Presenting Complaints:

C/O PAIN IN THROAT SINCE 2 DAYS

ON EXAMINATION PATIENT HAS INFLAMMED TONSILS WITH EXUDATES

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

Diagonosisi Acute tonsillitis, unspecified, Pain in throat — ICD Code J03.90, R07.0

12.Etiology:

13.In case of Injury:mode of Injury/place of Injury

14.Plan / Details of Management

a.Procedure Office 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. — CPT code9

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
0027-142201-0831	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	POWDER FOR SOLUTION (30S, SACHET)	5	Take 1sachet 2 Time(s) per Day For 5 Day(s) after meal
0005-119805-1172	(PREDNISOLONE : 5 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal
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) after meal

Date: 12-03-24(dd/mm/yy)

Signature and Stamp

Doctor's Name Maimoona

Physician Code DHA-P-65822348 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: 12-03-24(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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