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:

Pain in the anus especially during and immediately after defecation.

Has intermittent fever

DRE: inspection; good perianal hygiene, mild longitudinal tear on the 9 O clock position.

Anus could not admit a finger due to pain and spasm.

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiOther ischiorectal abscess, Acute anal fissure, Fever, unspecified ICD Code K61.39, K60.0, R50.9

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureIntramuscular injection,CLOFEN ,Free follow-up consultation of the same diagnosis within 7 days of initial consultation by a General Practitioner. CPT code96372,0005-149902-1021,9.1

b.Laboratiry Test:

c.Radiology / Investigations:

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

16.

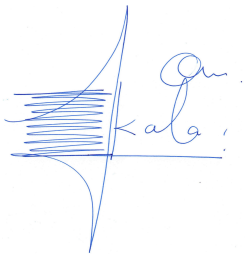
PRESCRIPTION WITH DOSAGE & DURATION

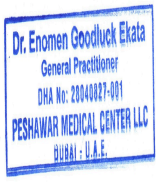
Code	Generic	Dosage	Duration	Instructions
0188-232401-0392	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	FILM COATED TABLETS (28S, BLISTER PACK)	14	Take 1Tablets 2 Time(s) per Day For 14 Day(s) others
2104-103201-0391	(CIPROFLOXACIN : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER)	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal
0027-149903-2231	(DICLOFENAC SODIUM : 100 MG) RECTAL SUPPOSITORIES	RECTAL SUPPOSITORIES (5S, STRIP)	10	Take 1Suppository 1Time(s) perDay For 10 Day(s) evening

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

Doctor's Name Enomen Goodluck

Signature and Stamp





Physician Code DHA-P-28040827 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

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

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HealthNet