1.HealthNet Policy Number I038-000-119215707-01 2. Authorization Code:

2.Patient Name SHIRLEY AURELIO MARTINS

3.Patient Date of Birth & Sex 15-03-84(dd/mm/yy) ☐ Male ☑ Female

Mobile No.0509207512

5.Nature of illness or Injury ☐ Acute ☐ Chronic ☐ Emergency

6.Are You the patient's primary physician ☐ Yes ☐ No

7.Presenting Complaints:

pain and redness on the right eye.

symptoms started two days prior to presentation.

There is associated itchiness and tearing

Has no cough, no pain in throat and no running nose.

has no known allergies and is not asthmatic.

Had recently moved to a new house and has been sweeping a raising a lot of dust

not hypertensive and not diabetic.

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiOther mucopurulent conjunctivitis, right eye, Other pruritus, Ocular pain, right eye ICD Code H10.021, L29.8, H57.11

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. CPT code9

b.Laboratiry Test:

c.Radiology / Investigations:

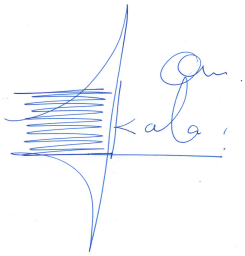
15.In Case of Hospitalization: Date of Addmission: Date of Discharge:

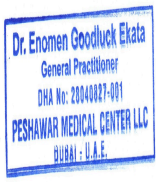
16. PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
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
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) Both Eyes
0005-119805-1172	(PREDNISOLONE : 5 MG) TABLETS	TABLETS (20S, BLISTER PACK)	7	Take 2Tablets 1Time(s) perDay For 7 Day(s) after meal
0070-166601-0651	(BETAMETHASONE : 0.05%) (GENTAMICIN : 0.10%) OINTMENT	OINTMENT (15G, TUBE)	5	Take 1Ointment 1Time(s) perDay For 5 Day(s) Both Eyes
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) after meal

Date: 30-03-24(dd/mm/yy)

Signature and Stamp





Doctor's Name Enomen Goodluck

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: 30-03-24(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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

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