1.HealthNet Policy Number I038-000-120415703-01 2. Authorization Code:

2.Patient Name Farrukh Liaqat Liaqat Hussain

3.Patient Date of Birth & Sex 14-04-80(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0529442504

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

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

7.Presenting Complaints:

For follow up

still has fever and generalized body pains.

CBC report shows leukocytosis with neutrophilia.

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiFever, unspecified, Elevated white blood cell count, unspecified, Bacterial infection, unspecified ICD Code R50.9, D72.829, A49.9

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.,Administered intravenously,CEFTRIAXONE-TABUK IV,DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION CPT code96372,0005-149902-1021,9.1,96365,0195-107704-0801,0125-122107-1022

b.Laboratiry Test:

c.Radiology / Investigations:

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

16.

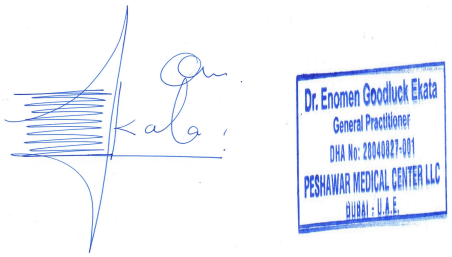
PRESCRIPTION WITH DOSAGE & DURATION

| Code | Generic | Dosage | Duration | Instructions |
|---|---|---|---|---|
| 1516-107902-1171 | (IBUPROFEN : 400 MG) TABLETS | TABLETS (24S, 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: 02-04-24(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: 02-04-24(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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