## **eASOAP FORM**

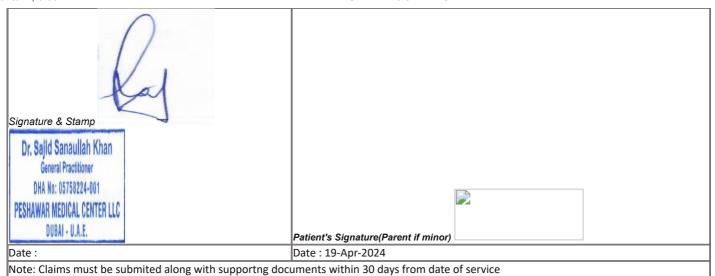


**ADMINISTRATIVE** The member is allowed for **Out Patient** at the Irham Medical Center Arjan

Patent Name:	MUNEEBA AMMAR	Gender:	Female	Validity Between:	21/02/2024 and 20/02/2025
Card No:	2D7C-EE8D-9AE5-231C	DOB:	12/30/1996 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
Natonal ID:	784-1996-4608131-7	Service Date:	19-Apr-2024	Radiology:	Covered
		Patent's Tel No:	0507288468		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	42923	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultaton :		Laboratory:	Covered
Referral No:					
Referred Service:					

SUBJECTIVE A	SSESSMENT								
Symptom(s) a	s described by the p	atent (Chief	Complaint	:):			Date of	f Symptoms	s/illness started
Complaint							DD	MM	YYYY
co pussy no	dules on hip 5	days							
fever on an	d off 5 days								
oe									
2 pusy nodu	lles on hips inflame	d area aroun	d the nodu	ules ill looking	S				
Past Medical	Surgical History?			○Yes		ONo	Date o		s/illness started
rast Wieulcan				o res		ONO	DD	MM	YYYY
Obs/Gyn Clair	ms.						Date o	f Symptom	s/illness started
Obs/Gyll Clall	115						DD	MM	YYYY
Para	☐ Gravida:	☐ AB:	LMP:	Marital Status	<b>:</b> :	Marital Date:			
What date did	l the Patient first feel sa	I ame / similar S	I Symptom(s	l ) : dd mm yyyy					
Is the Patient ι	ınder any type of Trea	tment? O Ye	es O No	if yes, indicate	e what Asses	sment and since w	hen:		
	ASSESSMENT(To be	completed by	Physician)						
Clinical Findir	ngs :			:	Vital Signs : ∶18	B/P : 94	T:36.7	HR:	102 F
Assessment/I IN	Diagnosis : OA IDICATE DIAGNOSIS		Chronic OM	O Confirmed	d OSusp	ected			
Туре		Code		Diagnosis					
Primary		R50.9		Fever, unspecified					
Secondary		L02.33		Carbuncle of buttock					
Secondary L02.91 Cutaneo			Cutaneous ak	oscess, unspe	ecified				
ACCIDENT/O	CCUPATIONAL Claim	Informaton	(complete	if claim is a re	sult of accid	ent or work related	d illness/inju	ry)	
Accident or illness due to work? Injury due accident?			to road	Describe how the accident or work related injury/illness occur:					
○ Yes ○ No	)		○Yes ○	No					
					I				

85652 Sedimentation rate, erythrocyte; automated  81040 C-reactive protein;  81001 Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy  96365 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour  87070 Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates  9 GP Consultation  Code  General Consultation  Code  (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) FILM COATED TABLETS  (VITAMIN B12 (CYANOCOBALAMIN) : 18 MCG) (VITAMIN D3 (CHOLECALCIFEROL) : 5 MCG) (VITAMIN B12 (CYANOCOBALAMIN) : 18 MCG) (VITAMIN D3 (CHOLECALCIFEROL) : 5 MCG) (VITAMIN E : 26.84 MG) (VITAMIN K1 : 25 MCG) (VITAMIN CADED TABLETS  (VITAMIN B12 (CYANOCOBALAMIN) : 18 MCG) (VITAMIN D3 (CHOLECALCIFEROL) : 5 MCG) (VITAMIN E : 26.84 MG) (VITAMIN K1 : 25 MCG) (VITAMIN CADED TABLETS  (VITAMIN B12 (CYANOCOBALAMIN) : 18 MCG) (VITAMIN CADED TABLETS  (VITAMIN B12 (CYANOCOBALAMIN) : 18 MCG) (VITAMIN CADED : 10 MG) (IDDINE (AS CARBONATE + CALCIUM PHOSPHATE DIBASIC) : For 30 MG) (IDDINE (AS CALCIUM PHOSPHATE DIBASIC) : For 30 Day(s) others  (VITAMIN E : 26.84 MG) (CHR  DOMAG) (POLIC ACID : 2%) CREAM  1 Take 1Tablets  Time(s) per D For 30 Day(s) others  (FUSIDIC ACID : 2%) CREAM  1 Take 1 Tablets  Time(s) per D For 1 Day(s)  Take 1 Tablets  Time(s) per D For 1 Day(s)  Take 1 Tablets  Time(s) per D For 1 Day(s)  Take 1 Tablets  Time(s) per D For 1 Day(s)  Take 1 Tablets  Time(s) per D For 1 Day(s)  Take 1 Tablets  Time(s) per D For 1 Day(s)  Take 1 Tablets  Time(s) per D For 1 Day(s)  Take 1 Tablets  Time(s) per D For 1 Day(s)  Take 1 Tablets  Time(s) per D For 1 Day(s)  Take 1 Tablets  Time(s) per D For 1 Day(s)  Take 1 Tablets  Time(s) per D For 1 Day(s)	CPT Code	Treatment					Туре		Price	
Sedimentation rate, erythrocyte; automated  Lab 8.00  Refido Creactive protein;  Urinalysis, by dip stck or tablet reagent for billrubin, glucose, hemoglobin, ketones, leukocytes, nirtre, pH, protein, specific gravity, urobilinogen, any number of these constituents, automated, with microscopy  Peace of the constituents, automated, with microscopy  General Collurar, bacterial; any other source except urine, blood or stool, aerobic, with isolation and up to 1 hour  Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and up to 1 hour  Code General Consultation  Take 1 Tablets  Take 1 Tablets  Take 1 Tablets  Take 1 Tablets  T	107702-	MESPORIN I.M.						су	25.0000	
Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrice, pht, protein, specific gravity, urobilinogen, any number of these constituents, automated, with microscopy  96365		Sedimentation rat	e, erythrocyte; automa	ated			Lab		8.0000	
Lab   8.00   8	86140	C-reactive protein	;				Lab		15.000	
up to 1 hour  Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of Isolates  General  General  General  Consultation  General  Consultation  General  Consultation  Code  Generic  Duration  Take 1 Tablets Time(s) per Defor 30 any (s) others  Take 1 Tablets Time(s) per Defor 30 any (s) others  Take 1 Tablets Time(s) per Defor 30 any (s) others  Take 1 Tablets Time(s) per Defor 30 any (s) others  Take 1 Tablets Time(s) per Defor 30 any (s) others  Take 1 Tablets Time(s) per Defor 30 any (s) others  Take 1 Tablets Time(s) per Defor 30 any (s) others  Take 1 Tablets Time(s) per Defor 30 any (s) others  Take 1 Tablets Time(s) per Defor 30 any (s) others  Take 1 Tablets Time(s) per Defor 30 any (s) others  Take 1 Tablets Time(s) per Defor 30 any (s) others  Take 1 Tablets Time(s) per Defor 30 any (s) others  Take 1 Tablets Time(s) per Defor 30 any (s) others  Take 1 Tablets Time(s) per Defor 1 any (s) others  Take 1 Tablets Time(s) per Defor 1 any (s) others  Take 1 Tablets Time(s) per Defor 1 any (s) others  Take 1 Tablets Time(s) per Defor 1 any (s) others  Take 1 Tablets Time(s) per Defor 1 any (s) others  Take 1 Tablets Time(s) per Defor 1 any (s) others  Take 1 Tablets Time(s) per Defor 1 any (s) others  Take 1 Tablets Time(s) per Defor 1 any (s) others  Take 1 Tablets Time(s) per Defor 1 any (s) others  Take 1 Tablets Time(s) per Defor 1 any (s) others  Take 2 Tablets Time(s) per Defor 1 any (s) others  Take 2 Tablets Time(s) per Defor 1 any (s) others  Take 2 Tablets Time(s) per Defor 1 any (s) others  Take 2 Tablets Time(s) per Defor 1 any (s) others  Take 2 Tablets Time(s) per Defor 1 any (s) others  Take 2 Tablets Time(s) per Defor 1 any (s) others  Take 2 Tablets Time(s) per Defor 1 any (s) others  Take 2 Tablets Time(s) per Defor 1 any (s) others  Take 2 Tablets Time(s) per Defor 1 any (s) others  Take 2 Tablets Time(s) per Defor 1 any (s) others  Take 2 Tablets Time(s) per Defor 1 any (s) others  Take 2 Tablets Time(s) per Defor 1 any	81001	leukocytes, nitrite	, pH, protein, specific g	gravity, urobilii			Lab		8.0000	
general Consultation General Consultation General Consultation General Consultation General Consultation General Consultation Duration Instructions (General Consultation) General Consultation General Consultati	96365		on, for therapy, prophy	/laxis, or diagr	osis (specify substance or dru	g); initial,	Co.Pay		40.000	
Consultation   Cons	87070			pt urine, bloo	d or stool, aerobic, with isolati	on and	Lab		25.000	
Take 1Tablets   Take 1 Tablets   Take	9	GP Consultation							25.000	
CESOMEPRAZOLE (AS MAGNESIUM): 20 MG) FILM COATED TABLETS   7   Time(s) per D For 7 Day(s) others	Code	Generic					 Duration	Instruct	ions	
(VITAMIN E : 26.84 MG) (VITAMIN X I : 25 MCG) (VITAMIN C (ASCORBIC ACID) : 120 MG) (BIOTIN : 40 MCG) (FOLIC ACID : 0.4 MG) (PANTOTHENIC ACID : 10 MG) (IODINE (AS POTASSIUM IODIDE) : 0.15 MG) (CALCIUM (AS CARBONATE + CALCIUM PHOSPHATE DIBASIC) : 100 MG) (IPHOSPHORUS (AS CALCIUM PHOSPHATE DIBASIC) : 48 MG) (MANGANESS UNIFATE : 4 MG) (CHR  2281- 128401- 0152  (FUSIDIC ACID : 2%) CREAM  (METRONIDAZOLE : 500 MG) FILM COATED TABLETS  (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS  (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS  (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS  (CAFFEIN	533801-	(ESOMEPRAZOLE (AS	MAGNESIUM) : 20 MC	6) FILM COATE	D TABLETS		Take 1Tablet Time(s) per For 7 Day(s)			
128401- 0152  (FUSIDIC ACID : 2%) CREAM  (FUSIDIC ACID : 2%) CREAM  (FUSIDIC ACID : 2%) CREAM  (IT Time(s) per D For 1 Day(s)  Take 17ablests Time(s) per D For 7 Day(s) others  (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS  (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS  (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS  (CAFFEINE : 65 MG	993001-	(VITAMIN E : 26.84 M (BIOTIN : 40 MCG) (F POTASSIUM IODIDE) 100 MG) (PHOSPHOF MG) (IRON (FERROUS	IG) (VITAMIN K1 : 25 M OLIC ACID : 0.4 MG) (P. : 0.15 MG) (CALCIUM ( RUS (AS CALCIUM PHO!	ICG) (VITAMIN ANTOTHENIC A AS CARBONAT SPHATE DIBAS	I C (ASCORBIC ACID) : 120 MG) ACID : 10 MG) (IODINE (AS E + CALCIUM PHOSPHATE DIB IC) : 48 MG) (MAGNESIUM OX	ASIC) : IDE : 45	30	Time(s) For 30 D	per Day	
116604-0391 (METRONIDAZOLE : 500 MG) FILM COATED TABLETS 7 For 7 Day(s) others  1139-116206-1171 (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS 7 Take 1Tablets Time(s) per Day(s) others  10005-107001-0051 (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS 7 Take 2Tablets Time(s) per Day(s) others  10005-107001-0051 (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS 7 For 7 Day(s) others  10005-107001-0051 (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS 7 For 7 Day(s) others  10005-107001-0051 (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS 7 For 7 Day(s) others  10005-107001-0051 (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS 7 For 7 Day(s) others  10005-107001-0051 (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS 7 For 7 Day(s) others  10005-107001-0051 (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS 7 For 7 Day(s) others  10005-107001-0051 (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS 7 For 7 Day(s) others  10005-107001-0051 (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS 7 For 7 Day(s) others  10005-107001-0051 (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS 7 For 7 Day(s) others  10005-107001-0051 (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS 7 For 7 Day(s) others  10005-107001-0051 (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS 7 For 7 Day(s) others  10005-107001-0051 (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS 7 For 7 Day(s) others  10005-107001-0051 (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS 7 For 7 Day(s) others  10005-107001-0051 (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS 7 For 7 Day(s) others  10005-107001-0051 (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS 7 For 7 Day(s) others  10005-107001-0051 (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS 7 For 7 Day(s) others  10005-107001-0051 (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS 7 For 7 Day(s) others  10005-107001-0051 (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS 7 For 7 Day(s) others  10005-107001-0051 (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS 7 For 7 Day(s) others  10005-10	128401-	(FUSIDIC ACID : 2%) (	USIDIC ACID : 2%) CREAM 1 Tim							
10139- 116206- 1171	116604-	(METRONIDAZOLE : 500 MG) FILM COATED TABLETS 7								
CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS   Time(s) per D For 7 Day(s) others	116206-	(CLAVULANIC ACID :	125 MG) (AMOXICILLIN	I : 875 MG) TA	BLETS		7	Time(s) For 7 Da	, , ,	
the following required  Surgery:  Other Procedures:  If yes please specify  In-patient Required? Length of Stay Indicate Provider Indicate	107001-	(CAFFEINE : 65 MG) (	PARACETAMOL : 500 N	ng) caplets			Take 2Tablet Time(s) per I For 7 Day(s)			
In-patient Required? Length of Stay  In-patient Required? Length of Stay  Indicate Provider  Indicate Provid	O Pharmac	y:	Estmated Costs		O Laboratory / Radiology:	Estm	nated Cost	s		
In-patient Required ? Length of Stay Indicate Provider Estimate Cost pereby certfy that all information mentioned are correct that the medical services shown on this form were edically indicated & necessary for the management of is case.  Indicate Provider Indicat			O Surgery:		O Endoscopy:					
In-patient Required? Length of Stay Indicate Provider Estimate Cos thereby certfy that all information mentioned are correct that the medical services shown on this form were edically indicated & necessary for the management of is case.  I hereby authorize any Healthcare Provider, Insurer, Employer or other Organiza release any information regarding my medical condition and history to NEXtCARI the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent.	the followi	ng required	O Physiotherapy:		Other Procedures:		_			
thereby certfy that all informaton mentoned are correct that the medical services shown on this form were edically indicated & necessary for the management of is case.  I hereby authorize any Healthcare Provider, Insurer, Employer or other Organiza release any informaton regarding my medical conditon and history to NEXtCARI the purpose of determining insurance benefts. Medical management is the sole responsibility of doctor and the patent.					If yes please specify					
thereby certfy that all informaton mentoned are correct that the medical services shown on this form were edically indicated & necessary for the management of is case.  I hereby authorize any Healthcare Provider, Insurer, Employer or other Organiza release any informaton regarding my medical conditon and history to NEXtCARI the purpose of determining insurance benefts. Medical management is the sole responsibility of doctor and the patent.	In-patient R	equired ? Length of Sta	у		Indicate Provider			Estimat	e Cost	
	hereby cert that the m edically ind is case.	fy that all informaton i edical services shown o licated & necessary for	mentoned are correct on this form were the management of	release any ir the purpose o	nformaton regarding my medic of determining insurance benej	al conditor	n and histo	ry to NEX	tCARE fo	
i / rax (important):			aullah							
	el / ⊦ax (imp	ortant):		<u> </u>						



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