1.HealthNet Policy Number I038-000-118180126-01 2. Authorization Code:

2.Patient Name SIDDIQUE AHMED ABDUL KODDUS

3.Patient Date of Birth & Sex 06-04-86(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0559913228

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

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

7.Presenting Complaints:Generalized body pains, nasal congestion, cough and pain in throat.

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiAcute upper respiratory infection, unspecified, Gout, unspecified, Hyperlipidemia, unspecified, Allergic rhinitis, unspecified ICD Code J06.9, M10.9, E78.5, J30.9

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureBlood Count Complete Auto&Auto Difrntl Wbc Count,C-Reactive Protein,Uric Acid Blood,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 code85025,86140,84550,9

b.Laboratiry Test:

c.Radiology / Investigations:

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

16.

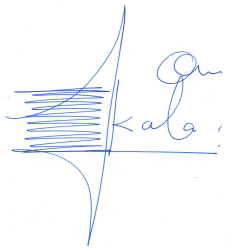
PRESCRIPTION WITH DOSAGE & DURATION

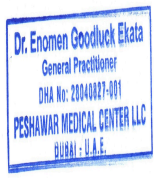
Code	Generic	Dosage	Duration	Instructions
0005-119803-1171	(PREDNISOLONE : 20 MG) TABLETS	TABLETS (20S, BLISTER PACK)	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) others
5253-649501-3851	(MOMETASONE FUROATE (AS MONOHYDRATE) : 50 MCG/DOSE) NASAL SPRAY	NASAL SPRAY (120 DOSE, PUMP SPRAY)	7	Take 1Spray 2Time(s) perDay For 7 Day(s) others
1204-571401-1161	(GUAIFENESIN : 100 MG/5ML) (PSEUDOEPHEDRINE HCL : 30 MG/5ML) (TRIPROLIDINE HCL : 1.25 MG/5ML) SYRUP	SYRUP (120ML, GLASS BOTTLE)	7	Take 10ML 3 Time(s) per Day For 7 Day(s) after meal
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	14	Take 1Tablets 2 Time(s) per Day For 14 Day(s) others
1516-107902-1171	(IBUPROFEN : 400 MG) TABLETS	TABLETS (24S, BLISTER PACK)	12	Take 1Tablets 2Time(s) perDay For 12 Day(s) after meal
0005-148701-1171	(LORATADINE : 10 MG) TABLETS	TABLETS (10S, BLISTER PACK)	10	Take 1Tablets 1Time(s) perDay For 10 Day(s) evening

Date: 30-04-24(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: 30-04-24(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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HealthNet