1.HealthNet Policy Number I038-000-118260850-01 2. Authorization Code:

2.Patient Name SHIHABUDHHEN KUNNATH

3.Patient Date of Birth & Sex 30-03-86(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0581761961

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

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

7.Presenting Complaints:

severe sore high fever and severe cough all started since yesterday

severe body pain

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiAcute pharyngitis, unspecified, Acute bronchitis, unspecified, Fever, unspecified, Cough, Pain, unspecified ICD Code J02.9, J20.9, R50.9, R05, R52

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureCEFTRIAXONE-TABUK IV,DEXAMETHASONE SODIUM PHOSPHATE,CLOFEN ,IV fluid admisitration,5% W/V DEXTROSE 0.45% & W/V SODIUM CHLORIDE,Intravenous Injection,Blood Count Complete,C reactive Protein,Gp Consultation CPT code0195-107704-0801,0125-122107-1022,0005-149902-1021,96360,2849-100143-0991,96374,85025,86140,9

b.Laboratiry Test:

c.Radiology / Investigations:

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

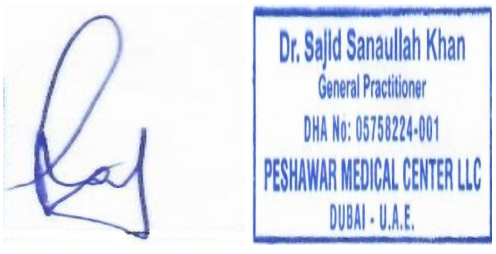
16.

PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0102-124502-1161	(SALBUTAMOL : 2 MG/5ML) SYRUP	SYRUP (120ML, BOTTLE)	5	Take 5ML 3 Time(s) per Day For 5 Day(s) others
0252-148701-1172	(LORATADINE : 10 MG) TABLETS	TABLETS (10S, BLISTER PACK)	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others
0278-107902-0391	(IBUPROFEN : 400 MG) FILM COATED TABLETS	FILM COATED TABLETS (30S, BLISTER PACK)	5	Take 1Tablets 4 Time(s) per Day For 5 Day(s) others
0139-116207-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS	TABLETS (20S, BLISTER PACK)	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others

Date: 24-07-23(dd/mm/yy)

Signature and Stamp



Doctor's Name Sajid Sanaullah

Physician Code DHA-P-5758224 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: 24-07-23(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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