1.HealthNet Policy Number I038-000-118368779-01 2. Authorization Code:

2.Patient Name ANEES AHMED NAZIR AHMED

3.Patient Date of Birth & Sex 11-05-89(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0569176872

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

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

7.Presenting Complaints:severe palpitation

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiLumbago with sciatica, unspecified side, Low back pain, Essential (primary) hypertension, Mixed hyperlipidemia ICD Code M54.40, M54.5, I10, E78.2

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureCLOFEN ,5% W/V DEXTROSE 0.45% & W/V SODIUM CHLORIDE,DEXAMETHASONE SODIUM PHOSPHATE,IV fluid admisitration,Intravenous Injection,Gp Consultation CPT code0005-149902-1021,2849-100143-0991,0125-122107-1022,96360,96374,9

b.Laboratiry Test:

c.Radiology / Investigations:

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

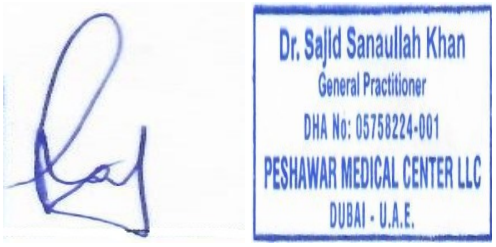
16.

PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0188-130101-0392	(PROPRANOLOL HCL : 40 MG) FILM COATED TABLETS	FILM COATED TABLETS (1000S, PLASTIC BOTTLE)	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) others
0005-149903-2231	(DICLOFENAC SODIUM : 100 MG) RECTAL SUPPOSITORIES	RECTAL SUPPOSITORIES (5S, STRIP)	5	Take 1Suppository 1 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

Date: 30-07-23(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: 30-07-23(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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