CONSULTATION FORM

Dear Doctor, you are kindly requested to complete this Consultation Form and fax it to NAS Claims Centre at 02-6766227**. For prescriptions, kindly use Prescription/Advice Form.**

PATIENT INFORMATION

FAMILY NAME _____ **GIVEN NAME** _____

DATE OF BIRTH _____ **GENDER** _____

CARD NBR: _____ **PAYER** _____

CASE INFORMATION **ACUTE** ☐ **CHRONIC** ☐ **PRE-EXISTING** ☐ **INJURY** ☐

DIAGNOSIS _____

AETIOLOGY _____

(Please indicate the exact cause in case of injuries and maternity-related cases)

SYMPTOMS:

CLINICAL FINDINGS:

REMARKS

TREATING PHYSICIAN _____

HOSPITAL /CLINIC _____

CONSULTATION DETAILS **NEW** ☐ **FOLLOW-UP** ☐ **CONSULTATION FEES** _____

DOCTOR'S SIGNATURE AND STAMP _____ **DATE** _____

I hereby allow NAS authorized personnel to obtain any requisite medical details from my current and previous physicians and case files.

BENEFICIARYS' SIGNATURE _____

NAS Administration Services , P.O Box 44505 Abu Dhabi , UAE Tel : 02-6777997 Fax : 02- 6766227