

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 <input type="checkbox"/> FOLLOW-UP <input type="checkbox"/> CONSULTATION FEES _____

Patient Consultation Report Form

S Ashworth

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