ER / HOSPITALIZATION FORM

PATIENT INFORMATION

FAMILY NAME _____ **GIVEN NAMES** _____

DATE OF BIRTH _____ **GENDER** _____

CARD NUMBER _____ **PAYER** _____

CASE INFORMATION **IN-PATIENT** ☐ **DAYCARE** ☐ **ER Only** ☐

DIAGNOSIS _____

AETIOLOGY _____**(Pls indicate exact cause)**

IS CASE AN EMERGENCY (YES/NO) _____ **ADMISSION DATE** _____

HOSPITAL/ CLINIC _____ **PROPOSED LENGTH OF STAY** _____

REQUIRED PRE-OPERATIVE TESTS/MEDICATIONS:

PROCEDURE DETAILS

FOR SURGICAL CASES, PLEASE INDICATE PLANNED PROCEDURE. FOR MEDICAL CASES, PLEASE INDICATE MANAGEMENT PLAN

DOCTORS SIGNATURE AND STAMP _____

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