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MEDICAL REPORT ON HOSPITALIZATION, SURGERY, CHEMOTHERAPY, RADIOTHERAPY & KIDNEY DIALYSIS

Policy/Contract/Certificate No. : ___________________________________

Note : **To be completed by the Attending Physician / Surgeon at the claimant's expense.**

SECTION A : PATIENT'S PARTICULARS

1. Name of patient

2. NRIC number (new) ______ - ___ - ____

3. Other identification number

4. Age ___ years old

5. Gender ☐ Male ☐ Female

6. Date of Birth D D - M M - Y Y Y Y

7. Occupation

SECTION B : HOSPITALIZATION & SURGERY

1. Admission Date : D D - M M - Y Y Y Y

2. Discharge Date : D D - M M - Y Y Y Y

3. Full Diagnosis : ______________________

4. Diagnosis Date : D D - M M - Y Y Y Y

5. What was the underlying cause? ______________________

6. What were the symptoms presented? ______________________

7. Since when did the symptoms start? D D - M M - Y Y Y Y

8. Did the patient seek treatment for the above symptoms before seeing you? ☐ Yes ☐ No

   If yes, please give details. (a) Date : D D - M M - Y Y Y Y

   (b) Clinic / Hospital : ______________________

9. Has any investigations, tests or procedures been done? ☐ Yes ☐ No

   If yes, please give details. ______________________

10. Is the disease congenital or hereditary? ☐ Yes ☐ No

11. Is there possibility of having relapse? ☐ Yes ☐ No

12. Was the patient referred to you by any other doctor? ☐ Yes ☐ No

    If yes, please give details.

    (a) Referral Date : D D - M M - Y Y Y Y

    (b) Referral Doctor : ______________________

    (c) Clinic / Hospital : ______________________

    (d) Referral Reason : ______________________

13. If the condition was caused by an ACCIDENT, please give the following details :

    (a) Accident Date : D D - M M - Y Y Y Y

    (b) Time of Accident : H H : M M am / pm

    (c) Place of Accident : ______________________

    (d) Nature of Accident : ______________________

    (e) Injuries Sustained : ______________________

    (f) Was the patient under the influence of alcohol / drugs? ☐ Yes ☐ No

    If yes, please give details. ______________________

    (g) Is the condition self-inflicted? ☐ Yes ☐ No

    If yes, please give details. ______________________

14. For FEMALE patient only.

    (a) Was the patient pregnant at the time of hospitalization? ☐ Yes ☐ No

    If yes, how many months? ___ months

    (b) Was the patient's illness / accident related directly or indirectly to pregnancy / childbirth? ☐ Yes ☐ No

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15. Was there any surgery performed? ☐ Yes ☐ No

If yes, please give details.

☐ Major Surgery ☐ Minor Surgery Surgery Date : D D – M M – Y Y Y Y

(a) Type of surgery performed : ______

(b) MMA Code : ______

(c) Please describe the nature / parts / reason for the surgery to be performed.

______

______

16. Please give details of ALL consultation and treatment given.

Date	Treatment Details	Healing Progress

SECTION C : OUTPATIENT KIDNEY DIALYSIS & OUTPATIENT ANTI-CANCER CHEMOTHERAPY / RADIOTHERAPY

1. Is the patient currently on dialysis or recommended for dialysis treatment? ☐ Yes ☐ No

   If yes, please give details.

   (a) Date of first dialysis : D D – M M – Y Y Y Y

   (b) How frequent does the patient require to go for the dialysis treatment? ______ days / week

   (c) Please give details of the dialysis centre.

   Name of Dialysis Centre : ______

2. Is the patient currently on anti-cancer follow-up treatment? ☐ Yes ☐ No

   If yes, please give details.

   ☐ Chemotherapy ☐ Radiotherapy

   (a) Course of treatment recommended.

   ______

   ______

   (b) Duration of treatment.

   Date started : D D – M M – Y Y Y Y Date ended : D D – M M – Y Y Y Y

   (c) No. of sessions to be completed : ☐☐☐ times

SECTION D : MEDICAL HISTORY

1. Does the patient have any of the following conditions?

Condition			since when?	Treating Clinic / Hospital
(a) Hypertension	☐ No	☐ Yes	; since when? ______	______
(b) Diabetes Mellitus	☐ No	☐ Yes	; since when? ______	______
(c) Dyslipidaemia	☐ No	☐ Yes	; since when? ______	______
(d) Heart Disease	☐ No	☐ Yes	; since when? ______	______
(e) Kidney Disease	☐ No	☐ Yes	; since when? ______	______
(f) Liver Disease	☐ No	☐ Yes	; since when? ______	______

2. Does the patient have any other medical conditions or past medical history? ☐ Yes ☐ No

   If yes, please give details.

Diagnosis	Onset Date	Treating Clinic / Hospital

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3. If the patient was treated by any other doctor, please give details.

Diagnosis	Doctor's Name	Clinic / Hospital

4. Any further information which in your opinion will assist us in assessing the claim.

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SECTION E : ATTENDING DOCTOR'S DECLARATION

I hereby certify that :

☐ I am the above named patient's attending doctor and I have personally examined and treated him/her for the illness/injuries sustained; **OR**

☐ I have personally perused the above named patient's medical record;

and that the facts as stated above are all true to the best of my knowledge and information that I have perused and that no material fact has been withheld from the Company.

Signature **Official Hospital Stamp** **Date :** D D – M M – Y Y Y Y

Full Name : ______________________________

Hospital / Clinic : ______________________________

Telephone No. : ______________________________

Address : ______________________________

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