

**MEDICAL REPORT FOR ACCIDENTAL / HOSPITALIZATION / SURGICAL
PROCEDURE CLAIM**

(To be completed by Medical Attendant)

Policy Number

Part 1 – Medical Information

1. Name of Patient
2. NRIC Number
3. Is this condition due to an illness or an accident? Illness Accident
4. Date of diagnosis of illness / Date of accident
5. Diagnosis of the illness / injury
6. Cause of illness / injury
7. Is this a job-related injury? Yes No
If yes, please give details.
8. Date you were first consulted for the injury / illness.
9. Main complaints at this first consultation.
If treatment is due to **injury**, please provide details on nature and extent of injuries sustained
10. Has the patient been treated previously for this condition? Yes No
 - a. If YES, please state the date of first consultation.
 - b. Please indicate approximate date from which the patient first noticed symptoms of condition.
 - c. In your view, if the condition existed before symptoms became apparent to the patient, please indicate when this condition began to develop.
 - d. Was patient informed of the diagnosis and understood it?

11. Details of any permanent disability the patient sustained as a result of the illness / injury

12. Is the above condition associated with the following:

- | | | | | |
|---|-----|--------------------------|----|--------------------------|
| a. Any condition resulting from pregnancy, childbirth or miscarriage or abortion | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| b. Any form of dental care or surgery | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| c. Any treatment for obesity, weight management program | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| d. Eye test, refractive errors of eyes, photo refractive keratectomy, cosmetic or plastic surgery and the provision of appliances, including spectacles lenses, hearing aids, artificial organs or joints, wheelchairs and prosthesis | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| e. Any elective surgery, cosmetic or plastic surgery not necessitated by injury or illness | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| f. Routine health check-up, custodial or rest care | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| g. Mental illness and psychiatric disorders | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| h. Infertility, contraception, sterilisation, circumcision | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| i. Human Immunodeficiency Virus infection, AIDS or any sexually transmitted diseases | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| j. Birth defect or congenital anomalies | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| k. Alcohol, drug abuse or the use of unprescribed drugs where such drugs are required by law to be prescribed by a registered doctor | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| l. Participation as a professional in competitive sports | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| m. Self inflicted injury e.g. voluntary causing hurt, attempt suicide, participating in hazardous activity (e.g. scuba diving, bungee-jumping, mountaineering) | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

13. If your answer to any of the conditions listed under Question 12 is "Yes", please provide details.

Part 2 – Hospitalisation Room & Board

2.1. Name of hospital patient was admitted to:

2.2. Please indicate how the patient was admitted:

Emergency admission

Referral by a doctor

Please provide Doctor's name and address

2.3. Date and time of admission:

2.4. Date and time of discharge:

2.5. Date of medical leave

Part 3 – Surgical Procedure

3.1. Were surgical procedures performed on the patient?

Yes

No

If your answer is " Yes ", please put a tick in the box alongside the categories of procedures listed below:

a.

Skin

h.

Male Genital System

b.

Musculoskeletal System

i.

Female Reproductive System

c.

Respiratory System

j.

Endocrine System

d.

Cardiovascular System

k.

Nervous System

e.

Haemic & Lymphatic System

l.

Eye

f.

Digestive System

m.

Ear / Nose / Throat

g.

Urinary System

n.

Endoscopies

3.2. Please describe in detail the surgical operation(s) performed on the patient.

3.3. Please state the objective(s) of the operation(s)

3.4. If 2 or more of the surgical procedures were performed, were they performed under the same anaesthesia?

Yes No

If your answer is "No", please give details.

3.5. Date of surgical operation(s)

3.6. Is patient still under your care for this condition?

Yes No

If 'No', please give the date of the last consultation.

3.7. If no surgery was performed, was surgery advised?

Yes No

If 'Yes', please give reasons why patient did not proceed with the surgery.

Part 4 – Reference

4.1. Name and Address of doctor(s) previously consulted by patient for this condition

I hereby certify that the answers given are complete, full and true to the best of my knowledge.

Signature

Practice Stamp

Name

Date

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