

PRUSHIELD MEDICAL REPORT
(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 when.

 b. Please indicate approximate date from which the patient first noticed symptoms of medical condition or injury.

 c. Date when the patient or his next of kin is aware or informed of the condition before symptoms became apparent

 d. When did this condition begin to develop

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

12. Is the illness or injury and the treatment prescribed associated with the following:

- | | | | | |
|---|-----|--------------------------|----|--------------------------|
| a. Congenital anomalies, hereditary conditions and disorders | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| b. Mental illness and personality disorders | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| c. Pregnancy, or any form of hospitalization or treatment relating to pregnancy, childbirth, abortion or miscarriage | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| d. Infertility, sub-fertility, assisted conception or any contraceptive treatment | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| e. Treatment of sexually transmitted diseases | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| f. Acquired Immunodeficiency Syndrome (AIDS), AIDS related complex or infection by Human Immunodeficiency Virus (HIV) | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| g. Treatment of self-inflicted injuries, or injuries resulting from attempted suicide | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| h. Treatment for drug addiction or alcoholism | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| i. Cosmetic surgery except for medical reasons | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| j. Dental treatment except for medical reasons | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| k. Sex change operations | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| l. Treatment of Injuries arising from direct participation in civil commotion, riots or strikes | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| m. Treatment of Injuries arising directly or indirectly from nuclear fallout, terrorism, wars and related risks | 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. Date and time of admission

2.3. Date and time of discharge

2.4. Date of medical leave

2.5. Please indicate how the patient was admitted

Emergency admission

Referral by a doctor (please provide Doctor's name and practice institution)

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. <input type="checkbox"/> Skin | h. <input type="checkbox"/> Male Genital System |
| b. <input type="checkbox"/> Musculoskeletal System | i. <input type="checkbox"/> Female Reproductive System |
| c. <input type="checkbox"/> Respiratory System | j. <input type="checkbox"/> Endocrine System |
| d. <input type="checkbox"/> Cardiovascular System | k. <input type="checkbox"/> Nervous System |
| e. <input type="checkbox"/> Haemic & Lymphatic System | l. <input type="checkbox"/> Eye |
| f. <input type="checkbox"/> Digestive System | m. <input type="checkbox"/> Ear / Nose / Throat |
| g. <input type="checkbox"/> Urinary System | n. <input type="checkbox"/> 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

Please give date of last consultation

3.7. What was the status of the patient's condition at the last consultation?

3.8. What was the treatment plan at the last consultation.

3.9. State date of next follow-up appointment

3.10. State the aim of the coming appointment

3.11. If patient is not under your care, please provide the name of the doctor and the practice institution you have referred him/her to:

Part 4 – Reference

4.1. Name and Practice Institution 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