

## PRUPARENT/PRUHOSPITAL INCOME ROOM & BOARD/SURGICAL BENEFIT MEDICAL REPORT FORM

(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 condition.	
	c. In your view, if the condition existed before symptoms became apparent to the patient, please indicate when this condition began to develop.	

1

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	No
b.	Any form of dental care of surgery	Yes	No
c.	Any treatment for obesity, weight management program	Yes	No
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	No
e.	Any elective surgery, cosmetic or plastic surgery	Yes	No
f.	Routine health check-up, custodial or rest care	Yes	No
g.	Mental illness and psychiatric disorders	Yes	No
h.	Infertility, contraception, sterilisation, circumcision	Yes	No
i.	Human Immunodeficiency Virus infection, AIDS or any sexually transmitted diseases	Yes	No
j.	Birth defect or congenital anomalies	Yes	No
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	No
l.	Participation as a professional in competitive sports	Yes	No
m.	Self inflicted injury e.g. voluntary causing hurt, attempt suicide, participating in hazardous activity (e.g. scuba diving, bungee-jumping, mountaineering)	Yes	No

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 hosp	ital patient was admitted to:		
2.2.	Please indicat	e how the patient was admitted:	Emergency a Referral by a Please provi	
2.3.	Date and time	of admission:		
2.4.	Date and time	of discharge:		
2.5.	Date of medica	al leave		
<u>Part</u>	3 – Surgical	<u>Procedure</u>		
3.1.	Were surgical	procedures performed on the patient?	Yes	No
	If your answer	r is "Yes ", please put a tick in the box along	side 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	1.	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, Yes No were they performed under the same anaesthesia? 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 date of 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

8	
N	
Name	
Date	
1.	

Pract	Practice Stamp					

Prudential Assurance Company Singapore (Pte) Limited 30 Cecil Street #30-01 Prudential Tower Singapore 049712 Postal Address: Robinson Road P.O. Box 492 Singapore 900942 Telephone: 6535 8988 Fax: 6734 9555 Part of Prudential Corporation plc Reg. No 199002477Z