PRUHospital Care360 **MEDICAL REPORT FORM**

(To be completed by the medical doctor)

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 (ddmmyyyy)				
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. (ddmmyyyy)				
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 (ddmmyyyy) 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				

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 programme	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
n.	Male or female sexual malfunction, function, any sexual disorder treatments, and sexual reassignment surgeries	Yes		No
o.	Organ transplant and the life assured is a donor	Yes		No
p.	Treatment for investigation or research (for example, experimental or new physiotherapy, medical techniques or surgical techniques, medical devices not approved by the Institutional Review Board and the Health Sciences Authority, and medical trials for medicinal products, whether or not these trials have a clinical trial certificate issued by the Health Sciences Authority or similar bodies)	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 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 (ddmmyyyy):

2.4 Date and time of discharge (ddmmyyyy):

2.5 Date of medical leave (ddmmyyyy):

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

b. ☐ Musculoskeletal System

c. ☐ Respiratory System

d. ☐ Cardiovascular System

e. ☐ Haemic & Lymphatic System

f. ☐ Digestive System

g. ☐ Urinary System

h. ☐ Male Genital System

i. ☐ Female Reproductive System

j. ☐ Endocrine System

k. ☐ Nervous System

l. ☐ Eye

m. ☐ Ear / Nose / Throat

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. Date of surgical operation(s) (ddmmyyyy)

3.5. Is patient still under your care for this condition? Yes ☐ No ☐

If 'No', please give date of last consultation. (ddmmyyyy)

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

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.
Please provide copy of referral letter for our review.

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

Signature

Name

Date

Practice Stamp