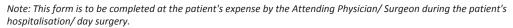
MEDICAL CLAIM - DOCTOR'S STATEMENT





Patient's Personal Details						
Name			Policy Number			
NRIC/Old IC/Passport/Birth Cert/Others	Date of Birth		Gender			
			Male	Female		
SECTION A : Medical History of The Patient						
Please provide the hospitalisation details.						
i. Admission Date		ii. Discharge Date				
Day Month	Year	Day	Month	Year		
2. Is the hospitalisation related to an accident?	_					
YES NO						
If Yes, please provide details of accident.						
i. Date & Time of accident						
Day Month	Year	am/pm				
ii. Nature of accident						
iii. Injury (ies) sustained						
3. The presenting signs and symptoms during the first con	sultation with you.					
4. The date when the patient first noticed the presenting	signs and symptoms					
Day Month	Year					
5. In your opinion, how long has the presenting signs and	 symptoms lasted prior to the fi	rst consultation with	vou?			
	\neg	131 (0113411411011 1111111	you:			
Day Month	Year					
6. Date the patient first consulted you for this condition.						
Day Month	Year					
7. Was the patient referred to you?	_					
YES NO						
If Yes, please provide details below and enclose a copy of the referral letter (if any):						
Name & Address of Referral Doctor						

8.	The following reco	rds upon the	admission:						
	i. Blood Pressure			mm	Hg				
	ii. Temperature			°c					
	iii. Pulse			bea	t per minute				
9. 	Final Diagnosis								
10.	10. Did you inform the patient on the diagnosis?								
	YES	NO	NO						
	If Yes, when?								
	Day		Month Year						
11.	What is the under	ying cause o	f the diagnosis?						
12.			to any of the following? If yes, please			erms.			
	Pregnancy/ Congenital/		nfertility/ Miscarriage or any complica liseases	itions arising ther	efrom				
	Influence of	_	hol onal/ Sleeping Disorder						
			conal, Sleeping Disorder I care/ Refractive errors correction						
	AIDS/STD/N		plation of laws/ Strike/ Riots						
	None of the		station of lawsy strike, mots						
13.	Please state all inv	estigations c	or tests which had been performed.						
	Date (DD/MN	//YYYY)	Investigation	/ Test		Investigation	Outcome/ Test Result		
14.	Please state detail	s and nature	of the treatment/ medication given to	o the patient.					
	Date (DD/MM/YYYY) Treatment/ Medication								
15.			used in ICU? If yes, please tick [✓] ar	nd indicate the du	=	T -) /DD /6 44 4 /4 /4 /4		
	Left ventricul		upport by invasive artificial airway rice (LVAD)) (DD/MM/YYYY)) (DD/MM/YYYY)		
			e Oxygenation (ECMO)) (DD/MM/YYYY)		
	Intra-aortic b		o (IABP) ith Arterial Line or Swan Ganz Cathete	er Insertion with) (DD/MM/YYYY)) (DD/MM/YYYY)		
	ventilatory support by invasive artificial airway								
			herapeutic Inotropic/Vasopressor Sup Hemoperfusion or Hemofiltration, for	•	(From	То) (DD/MM/YYYY)		
dialysis patient (From To) (DD/MM/YYYY)) (DD/MM/YYYY)		
16. If surgery was performed, please provide details of the surgical procedures rendered.									
	Date (DD/MM/YYYY)	Na	ture of Surgical Procedure(s)	Type of Ar (General/ Region	naesthetic al/ Local/ Sedation)	MMA/ PHFSR code	Name of Surgeon(s)		
				1	·				

17. Were there any complications that resulted in the healing being prolonged?							
18.	Any possibility of relapse?						
	YES	NO					
	Please complete the follow						
	Was the patient pregnant a	t the time of hospitalisation?					
	YES NO						
	If Yes, please state the gestational period and circle the applicable term.						
		Wee	eks / Months				
	0. Has the patient previously been treated/ hospitalised whether in this hospital or any other medical/ healthcare facilities for this or related illness/ condition, or any other disorders?						
	YES	NO					
	If Yes, please provide detai	ls as required below :					
	Date of Consultation (DD/MM/YYYY)	Illness/ Diagnosis	Types of Treatment Received/ Details of Hospitalisation	Name of Doctor & Name of Hospital/ Medical or Healthcare Facilities			
	(55)111117		Details of Hospitalisation	Wedical of Healthcare Facilities			
21. Please enclose copies of all reports, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, etc. and any relevant hospital reports that are available.							
SE	CTION B : Attending Do	ctor's Declaration					
Ιh	ereby certify that:						
	I am the patient's atten	ding doctor and I have personally o	examined and treated the patient for the illnesse	s/ injuries sustained; OR			
		ed the patient's medical records;					
а	nd that the facts as stated a	bove are all true to the best of my	knowledge and information that I have perused.				
	you are not the attending o						
Г	he Attending Doctor's Name	е о эрешанту:					
L	he reason(s) for completing	this document on behalf of the At	tending Doctor				
Г	inc reason(s) for completing	ans document on bendit of the At	tending Doctor.				
S	ignature	:	Date :				
N	lame	:					
Р	rofessional Qualification	:					
Ν	MMC/ Registration Number	:					
N	Name & Address of Hospital/ Clinic :						
C	Official Stamp of the Doctor	:					