PAEDIATRICIAN - DOCTOR'S STATEMENT

Note: This form is to be completed at the Patient's expense by the Attending Doctor.

PRUDENTIAL

Patient's Personal Details

Name

Policy Number

NRIC/Old IC/Passport/Birth Cert/Other

Date of Birth

Gender ☐ Male ☐ Female

SECTION A : Medical History of the Patient

1. Hospitalisation

Admission Date : ☐ Day ☐ Month ☐ Year

Discharge Date : ☐ Day ☐ Month ☐ Year

ICU/HDU (if applicable)

From : ☐ Day ☐ Month ☐ Year

To : ☐ Day ☐ Month ☐ Year

Incubation (if applicable)

From : ☐ Day ☐ Month ☐ Year

To : ☐ Day ☐ Month ☐ Year

2. Was the patient born prematurely?

☐ Yes ☐ No

If Yes, please state the gestational period and circle the applicable term.

☐ Weeks / Months

3. Presenting signs and symptoms (inclusive of Duration):

4. The following records upon the admission:

i. Blood Pressure ☐ mmHg

ii. Temperature ☐ °C

iii. Pulse ☐ beat per minute

5. Final diagnosis

6. Is the final diagnosis related to any of the following? (Please indicate [✓] or circle the relevant)

☐ Alcohol or Substance Abuse/ Addiction of the baby's mother

☐ Complication resulting from fertility treatment including in vitro fertilization

☐ Baby's mother has AIDS / is HIV positive

☐ Suicide or attempted suicide while sane or insane /Self-inflicted injuries of the baby's mother

7. Was the patient referred to you?

☐ YES ☐ NO

If Yes, please enclose a copy of the referral letter (if any) and answer the following:

a) Name of referred doctor / clinic

b) Address of the clinic

8. Has the patient been hospitalised for the same illness whether in this hospital or any other hospitals?

☐ YES ☐ NO

If Yes, please state details of previous admission as below :

Date of Admission (DD/MM/YYYY)	Hospital	Diagnosis / Illness	Treatment

9. Is the patient suffering from any other underlying illnesses besides the current medical condition?

☐ YES ☐ NO

If Yes, please provide details :

Date of Diagnosis (DD/MM/YYYY)	Underlying Illness	Doctor's Name / Address / Telephone No

10. Please state all investigations, tests or procedures which had been performed. ***Please attach a copy of all the test results.***

Date (DD/MM/YYYY)	Name of investigation / test / procedure	Doctor's Name / Address / Telephone No

11. Nature of treatment given and Date (DD/MM/YYYY)

Date (DD/MM/YYYY)	Nature of Treatment

12. For Surgery :

Date of surgery performed (DD/MM/YYYY)	Nature of operation performed	Name of surgeon	Type of implant (if any)

SECTION B : Attending Doctor's Declaration

I hereby certify that:

☐ I am the patient's attending doctor and I have personally examined and treated the patient for the illnesses/ injuries sustained; OR

☐ I have personally perused the patient's medical records;

and that the facts as stated above are all true to the best of my knowledge and information that I have perused.

If you are not the attending doctor, please state:

The Attending Doctor's Name & Speciality:

The reason(s) for completing this document on behalf of the Attending Doctor:

Signature : Date :

Name :

Professional Qualification :

MMC/ Registration Number :

Name & Address of Hospital/ Clinic :

Official Stamp of the Doctor :