

MEDICAL CLAIM - DOCTOR'S STATEMENT

Note: This form is to be completed at the patient's expense by the Attending Physician/ Surgeon during the patient's hospitalisation/ day surgery.



Patient's Personal Details

Name			Policy Number		
NRIC/Old IC/Passport/Birth Cert/Others	Date of Birth	Gender			
		<input type="checkbox"/> Male	<input type="checkbox"/> Female		

SECTION A : Medical History of The Patient

1. Please provide the hospitalisation details.

i. Admission Date

<input type="text"/> Day	<input type="text"/> Month	<input type="text"/> Year
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ii. Discharge Date

<input type="text"/> Day	<input type="text"/> Month	<input type="text"/> Year
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2. Is the hospitalisation related to an accident?

YES NO

If Yes, please provide details of accident.

i. Date & Time of accident

<input type="text"/> Day	<input type="text"/> Month	<input type="text"/> Year	<input type="text"/> am/pm
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ii. Nature of accident

<input type="text"/>

iii. Injury (ies) sustained

<input type="text"/>

3. The presenting signs and symptoms during the first consultation with you.

<input type="text"/>

4. The date when the patient first noticed the presenting signs and symptoms

<input type="text"/> Day	<input type="text"/> Month	<input type="text"/> Year
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5. In your opinion, how long has the presenting signs and symptoms lasted prior to the first consultation with you?

<input type="text"/> Day	<input type="text"/> Month	<input type="text"/> Year
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6. Date the patient first consulted you for this condition.

<input type="text"/> Day	<input type="text"/> Month	<input type="text"/> Year
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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

<input type="text"/>

8. The following records upon the admission:

- i. Blood Pressure mmHg
ii. Temperature °C
iii. Pulse beat per minute

9. Final Diagnosis

10. Did you inform the patient on the diagnosis?

- YES NO

If Yes, when?

Day Month Year

11. What is the underlying cause of the diagnosis?

12. Is the illness/ condition related to any of the following? If yes, please tick [✓] and circle the applicable terms.

- Pregnancy/ Childbirth/ Infertility/ Miscarriage or any complications arising therefrom
 Congenital/ Hereditary diseases
 Influence of Drugs/ Alcohol
 Nervous/ Mental/ Emotional/ Sleeping Disorder
 Cosmetic reason/ Dental care/ Refractive errors correction
 AIDS/ STD/ VD
 Self-inflicted injuries/ Violation of laws/ Strike/ Riots
 None of the above

13. Please state all investigations or tests which had been performed.

Date (DD/MM/YYYY)	Investigation/ Test	Investigation Outcome/ Test Result

14. Please state details and nature of the treatment/ medication given to the patient.

Date (DD/MM/YYYY)	Treatment/ Medication

15. If surgery was performed, please provide details of the surgical procedures rendered.

Date (DD/MM/YYYY)	Nature of Surgical Procedure(s)	MMA/ PHFSR code	Name of Surgeon(s)

16. Were there any complications that resulted in the healing being prolonged?

17. Any possibility of relapse?

YES NO

18. Please complete the following if the patient is **female**.

Was the patient pregnant at the time of hospitalisation?

YES NO

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

Weeks / Months

19. 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 details 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

20. Please enclose copies of all reports, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, etc. and any relevant hospital reports that are available.

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 :