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.

PRUDENTIAL

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

1. Please provide the hospitalisation details.

i. Admission Date ☐ Day ☐ Month ☐ Year

ii. Discharge Date ☐ 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 consultation 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 first consultation with 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

FORM ID 11601007

8. The following records upon the admission:

i. Blood Pressure _____ mmHg

ii. Temperature _____ ℃

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. Type of Essential Life Support used in ICU ? If yes, please tick [✓] and indicate the duration of usage.

☐ Mechanical Ventilation, support by invasive artificial airway (From _____ To _____) (DD/MM/YYYY)
☐ Left ventricular assist device (LVAD) (From _____ To _____) (DD/MM/YYYY)
☐ Extracorporeal Membrane Oxygenation (ECMO) (From _____ To _____) (DD/MM/YYYY)
☐ Intra-aortic balloon pump (IABP) (From _____ To _____) (DD/MM/YYYY)
☐ Mechanical Ventilation with Arterial Line or Swan Ganz Catheter Insertion, with ventilatory support by invasive artificial airway (From _____ To _____) (DD/MM/YYYY)
☐ Two or more concurrent therapeutic Inotropic/Vasopressor Support (From _____ To _____) (DD/MM/YYYY)
☐ Temporary Hemodialysis, Hemoperfusion or Hemofiltration, for non regular dialysis patient (From _____ To _____) (DD/MM/YYYY)

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

Date (*DD/MM/YYYY*)	Nature of Surgical Procedure(s)	Type of Anaesthetic (*General/ Regional/ Local/ Sedation*)	MMA/ PHFSR code	Name of Surgeon(s)

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

18. Any possibility of relapse?

☐ YES ☐ NO

19. 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

20. 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

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.

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 :