Medical Report

For Hospitalization/Inpatient & Surgery Treatment only

(To be completed by the doctor at the Insured's expense)

Please complete this form as fully as possible to assist us in early settlement of your claim.

1. Name of the Patient:	ID Number
2a. Present Admission:	
Date of first consultation with you:	
Symptoms presented at first condition:	
Diagnosis:	
How long condition lasted:	
Treatment given and response:	
Date Admitted:	**Date Discharged:**
Any Possibility of relapse? [ ] Yes [ ] No	
2b. If the patient was referred to you OR if patient had seen another doctor before consulting you, please give name and address of the doctor:	
Name:	**Address:**
2c. Is the condition suffered by the patient in any way related to alcoholism, drug addiction, depression, mental or functional disorder, venereal disease, pregnancy, miscarriage, childbirth or related conditions thereof? [ ] Yes [ ] No If Yes, please provide details below:	
2d. If hospitalized for injury, please provide details on nature and where and how the accident occurred, and whether he/she was under the influence of alcohol or drugs at the time of accident.	
2e. Is the condition self induced/inflicted? [ ] Yes [ ] No	

3. History:

(a) Has the patient previously suffered from the same illness/disease in respect of which he/she is now claiming?

[ ] Yes [ ] No If yes, please state:

Date when illness was first diagnosed:

Name and address of doctor who first treated him/her:

(b) Has the patient been admitted to any hospital before, either for the same or different cause?

[ ] Yes [ ] No If yes, please state:

Date admitted Date discharged

Name of Hospital:

Diagnosis: Date Diagnosed:

4. <u>Other Illness</u>:

Has the patient suffered from a related or any other disease? [ ] Yes [ ] No

If Yes, please (a) specify illness/disease:

(b) date when such illness/disease was diagnosed:

(c) give name and address of attending doctor:

5. <u>Surgery</u>:

If Patient had undergone surgery, please state: Minor [ ] Intermediate [ ] Major [ ]

Nature of Surgical Procedure performed:

Date of Operation: Surgeon's Fees: Anesthetist's Fees:

6. Please provide us with any other additional information that will enable the Company to assess this claim:

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Signature and stamp of Physician

Name: Contact Number:

Qualification: Date: