

# CREWMEMBER REFERRAL ASHORE FORM

Original: Office  
Copy: Shore Doctor  
Agent  
Ship's Doctor

Ship \_\_\_\_\_

Date \_\_\_\_\_

## SECTION TO BE COMPLETED BY VESSEL

Seaman's Name		Position	Crew No.
Date of Birth		Nationality	
Passport No.		Date of Issue	
Port of Engagement		Date of Engagement	
Port of Referral		Specialist	
Nature of sickness / injury		If this is a pre-existing condition, please explain:	
Date of onset of symptoms:			
Important Past Med History:			
Suspected Diagnosis:			
Location on/in Body:		Is person "work incapacitated" due to illness/injury? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Period of Incapacity: From:		To:	Date seaman ceased work:
Log entry made? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, attach extract of log entry to office copy			
Was seaman discharged due illness/injury? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, name of port Date			
Particulars of onboard medical treatment:		Port Agents Name & Address:	
<p><b>Please make the examinations, tests and x-rays, etc., which are chargeable to the vessel's account.</b></p> <p><b>Please note for dental consultations: The Company pays for emergency treatment only (e.g. examination, x-ray, amalgam filling, extraction). Expenses for cosmetic treatment are to be borne by the patient.</b></p> <p><b>Please advise the vessel of all medical results as soon as possible.</b></p>			
_____ Signature of Master/Staff Captain		_____ Signature of Ship's Doctor	

## SECTION TO BE COMPLETED BY SHORE DOCTOR

Diagnosis (pls print clearly)			
Treatment (pls print clearly)			
Fit for duty Yes <input type="checkbox"/> No <input type="checkbox"/>		Days unfit for duty	Hospitalisation required? Yes <input type="checkbox"/> No <input type="checkbox"/>
Days fit for light duty		Name & Address of Hospital	
Treatment terminated Yes <input type="checkbox"/> No <input type="checkbox"/>		Has reached "Maximum Medical Improvement"? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Estimated days to reach "Maximum Medical Improvement"?			
Travel Status:	Fit to Travel by Air <input type="checkbox"/> by Sea <input type="checkbox"/>	Unfit to travel by Air <input type="checkbox"/> by Sea <input type="checkbox"/>	
List special clinical examinations, if any:			
Seaman referred to a specialist? Name:		Field of specialisation:	
Specialist's remarks: (pls print clearly, on a separate sheet if required)			
Follow up treatment, if any, to be done at next port:			
Doctor's Name Address Telephone No.		_____ Doctor's signature	

## SECTION TO BE COMPLETED BY SHIP'S PHYSICIAN

Bill to
Telephone No.

**IMPORTANT: PLEASE ENSURE COPIES ARE RETURNED TO THE VESSEL IMMEDIATELY**