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| ***CREWMEMBER REFERRAL ASHORE FORM*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Ship*** | | | | |  | | | | | | | | | | | | ***Date*** | | | | | | | |  | | | | | | | *Original: Office*  *Copy: Shore Doctor*  *Agent*  *Ship's Doctor* | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***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 | | | | No |
| Period of Incapacity: | | | | | From: | | |  | | | | | To: | |  | | | | | | | Date seaman ceased work: | | | | | | | | | | | |  | | | | |
| Log entry made? | | | | | Yes | | | No | | | If yes, attach extract of log entry to office copy | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Was seaman discharged due illness/injury? | | | | | | | | | | | Yes | | | No | | | | If yes, name of port | | | | | | | | | |  | | Date | | | | |  | | | |
| Particulars of onboard medical treatment: | | |  | | | | | | | | | | | | | | Port Agents Name & Address: | | | | | |  | | | | | | | | | | | | | | | |
| ***Please make the examinations, tests and x-rays, etc., which are chargeable to the vessel’s account.***  ***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.***  ***Please advise the vessel of all medical results as soon as possible.*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | |  | | |  | | | |  | | | | | | | | | | | | | | | |  | | |
|  | 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 | | | No | | | | Days unfit for duty | | | | | | |  | | | | | Hospitalisation required? | | | | | | | | | Yes | | | No | | |
| Days fit for light duty | | | | |  | | | | | | | Name & Address of Hospital | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| Treatment terminated | | | | | Yes | | | No | | | | Has reached “Maximum Medical Improvement”? | | | | | | | | | | | | | | | | | | | | | Yes | | | No | | |
|  | | | | | | | | | | | | Estimated days to reach “Maximum Medical Improvement”? | | | | | | | | | | | | | | | | | | | | | |  | | | | |
| Travel Status: | | | | | Fit to Travel | | | | by Air | | | | by Sea | | | | | | Unfit to travel | | | | | | | | | | by Air | | | | by Sea | | | | | |
| 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** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |