Europ Assistance India
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PRELIMINARY MEDICAL REPORT

Patient's Name :_____Date of birth :_____Sex : _____

Nationality :_____Passport/ I.C. No:_____Date admitted : _____

TO BE COMPLETED BY ATTENDING DOCTOR

1. Date & Time of Accident/Injury/Sickness Contracted. (a) Date: _____ (b) Time:_____
2. History of presenting illness / mechanism of injury _____

_____

_____

3. Diagnosis / Nature of injury or illness _____
   (If no specific diagnosis is available, please state PROVISIONAL diagnosis)
4. Vital sign: T:_____°C/F BP:_____ P:_____/min Resp Rate:____/min SpO_2:____% (room air / O_2_____L/min)
5. Indication for admission (including important blood result/imaging etc):_____
6. (a) If condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed? : _____
7. (a) Date of first visit for this condition :_____ (b) Facility visited(if not current facility) _____
   (c) Relevant findings / investigation during first visit _____
8. Any other disease / past medical history or infirmity affecting present condition?

_____

9. Nature of medical treatment or surgical procedure(s) done or to be done:

_____

_____

10. Is illness/disease/disability/injury due to (*please circle appropriately*):

(a)	Influence of drugs/alcohol	: YES / NO	If 'yes', state alcohol level : _____
(b)	Pregnancy/Childbirth/Infertility	: YES / NO	
(c)	Congenital/Hereditary	: YES / NO	
(d)	Nervous/Mental/Emotional Disorder	: YES / NO	
(e)	HIV/AIDS/STD/VD	: YES / NO	
(f)	Riot/Natural Disaster	: YES / NO	

11. (a) Expected length of stay :_____ (b) Expected hospitalization costs : _____
12. Was there any treatment for this symptom/illness given before ? YES / NO
    If YES, please provide details of treatment date and type of treatment given :

Date	Description of Treatment
_____	_____
_____	_____

13. Please provide details of date(s) of consultations for other illness (if any):

_____

Attending Doctor's Name : _____ Designation : (MO/GP/Others (state):_____

Treating Doctor (Specialist) Name:_____ Specialty :_____

Hospital/Clinic :_____

Contact Details : (a) Clinic/Unit No.:_____Extn:_____
(b) Handphone No. _____

Date & Time of Report : (a) Date _____(b) Time _____

Attending Doctor Signature & Stamp