HealthMetrics

ATTENDING PHYSICIAN'S STATEMENT FORM

PATIENT ADMISSION DETAILS	
PATIENT NAME	COMPANY NAME
PATIENT ID (IC/ PASSPORT)	PATIENT ID (IC/ PASSPORT)
MRN/ ADMISSION NUMBER	ADMISSION DATE
DATE OF BIRTH/ AGE	SPECIALIST/ PHYSICIAN'S NAME

SECTION 1: ADMISSION DETAILS

1. a) Please confirm admission reason

☐ Surgical ☐ Medical ☐ Accident ☐ Delivery

b) Additional admission reason remarks

_____

2. a) If admission as due to accident, please confirm the date and details of the accident

Date and time of accident

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b) Elaborate the details of the accident

_____

_____

3. a) Was the patient pregnant during the hospitalisation?

☐ Yes ☐ No

b) If 'YES', please state the gestation period ☐☐ weeks

4. a) Symptoms/ Condition requiring admission

Symptom/ Condition description	Date first appeared	Date first consulted

b) How long has the patient been aware of the condition?

☐☐ Years ☐☐ Months

c) Patient's blood pressure/ temperature/ pulse

Blood pressure (mmHg) ☐☐☐ Temperature (°C) ☐☐☐ Pulse (BPM) ☐☐☐

5. a) Any previous consultation/ treatment/ hospitalisation for this symptom/illness or related conditions, or other disorders whether in this hospital or any other facilities?

☐ Yes ☐ No

b) Was the patient referred?

☐ Yes ☐ No

c) If 'YES', please provide the details of patient's referral

_____

d) If this condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed.

Disease/ Disorder	Treatment Details	Doctor/Hospital/Clinic	Date

e) Can the condition be manage under Outpatient basis?

☐ Yes ☐ No

e) If 'NO', please provide the reasons for admission

_____

6. a) Admitting/ Provisional Diagnosis (ICD-10 coding recommended)

Diagnosis Description	ICD-10 Code	Date Confirmed	Date First Advised

b) Cause and pathology underlying the present diagnosis

_____

7. Please confirm if the diagnosis was cause directly or indirectly by the following conditions

☐ Pregnancy/Childbirth/Caesarean section/Miscarriage/Prenatal/Postnatal/Sterilisation/Infertility

☐ Congenial/Hereditary Disease

☐ Influence of Drugs/Alcohol

☐ Nervous/Mental/Emotional/Sleeping Disorder

☐ Cosmetic surgery/Dental care/Refractive errors connection

☐ AIDS/HIV/STD/VD

☐ Self-inflicted Injuries/Violation of Laws/Strike/Riots

☐ None of the above

8. a) Any other medical / surgical conditions / illnesses present?

☐ Yes ☐ No

a) If 'YES', please elaborate

Condition / Illness Description	Date First Advised

9. a) Treatment plan(s), Investigation(s) and Surgical procedure(s) to be performed, if any

Treatment plan description	Estimated cost (RM)	Date (DD/MM/YYYY)

b) Estimated day(s) of stay

☐☐ Days

c) Expected discharge date

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SECTION 2: ATTENDING DOCTOR'S DECLARATION

I hereby certify that I have personally examined and treated the Patient for the injuries/illness described above and that the facts as stated above represent my medical opinion of their condition

Attending doctor / physician / surgeon's stamp and signature

Name

Date

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