PACIFIC CROSS VIETNAM

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ATTENDING PHYSICIAN'S REPORT

(All sections must be completed)

A. PARTICULARS OF THE PATIENT

Patient's Name: _____ ID/Passport No.: _____ Age: _____

Correspondence Address: _____

Email: _____ Telephone: _____ Fax: _____

B. ATTENDING PHYSICIAN'S REPORT (to be completed by attending physician/surgeon only)

SECTION 1

(a) What was the diagnosis you have made to the conditions of the patient and when was it made?

_____

(b) If confinement in a hospital was required, state diagnosis of condition in respect of which hospitalization was required?

_____

(c) (i) When did the symptom first appear? _____

(ii) When did patient first consult you on this condition? _____

(iii) To the best of your knowledge, has the patient ever had similar conditions or symptoms relating thereto or hospitalized for the same disorders? If "YES", please give dates and details

_____

(iv) To your knowledge, had patient previously consulted any other doctors for these symptoms? If "YES", please give names and address of the doctors

_____

_____

(d) Was the symptom a secondary condition to some other illness(es)? If "YES", please give details

_____

(e) Was the condition caused by or in anyway associated with the conditions mentioned below:

(i) the influence of drugs or alcohol intake?	Yes ❑	No ❑
(ii) AIDS	Yes ❑	No ❑
(iii) infertility or sterilization?	Yes ❑	No ❑
(iv) cosmetic or plastic surgery?	Yes ❑	No ❑
(v) psychiatric and mental disorder?	Yes ❑	No ❑
(vi) congenital deformities or anomalies?	Yes ❑	No ❑
(vii) suicide, insanity or self-inflicted injury?	Yes ❑	No ❑

(f) Are any of the conditions treated due to

(i) accident	Yes ❑	No ❑
(ii) sickness or injury due to patient's employment	Yes ❑	No ❑
(iii) pregnancy	Yes ❑	No ❑

If "YES", state approximate date of commencement of pregnancy _____

SECTION 2

(a) Period of hospitalization? Admission date: _____

Discharge date: _____

(b) Type of treatment given to the patient:

_____

(c) For surgical or maternity claims

(i) Name and nature of surgical or obstetrical procedure(s): _____

_____

(ii) Date(s) of procedure(s): _____

_____

(d) Discharge summary report:

_____

_____

SECTION 3

Is it possible to provide this treatment on an outpatient basis? If "YES", please give reasons of performing this treatment on an inpatient basis

_____

Name and Address of Attending Physician | Signature of Attending Physician with Stamp | Date (day/month/year)

4th Floor Continental Tower | 81-85 Ham Nghi Street | Nguyen Thai Binh Ward | District 1 | Ho Chi Minh City | Vietnam
Tel: (+84 8) 3821 9908 | Fax: (+84 8) 3821 9847 | www.pacificcross.com.vn | Email: inquiry@pacificcross.com.vn