

HOSPITAL BENEFIT & MEDICAL CLAIM - STATEMENT OF MEDICAL EXAMINER

SECTION B

1. Section B of this form is to be completed by a legally qualified and registered medical practitioner who has treated the patient.
2. Expenses incurred to obtain this report will be borne by the patient.
3. Please use extra page / paper where space provided is not sufficient.

Certificate No:

1. Name of Patient:
2. NRIC No. : BC / Old IC No. : Age:
3. Date of Admission:(dd/mm/yyyy) Time :(am/pm)
4. Date of Discharge:(dd/mm/yyyy) Time :(am/pm)
5. Final Diagnosis:
6. Date of diagnosis:(dd/mm/yyyy)
7. What was the underlying cause and pathology of the above diagnosis?
.....
8. Did you inform the patient of the diagnosis, if so, when? (dd/mm/yyyy)
9. When you first saw the patient for this illness/ condition (dd/mm/yyyy)
10. Have any investigation, tests or procedures been performed? Yes No
 - i. Date (dd/mm/yyyy)
 - ii. If so, what were the results?
 - iii. Please furnish a certified true copy of the results
11. Was the patient referred to you by any doctor? Yes No
 If yes, Referral Date (dd/mm/yyyy) Referral Reason(s):
 If yes, please indicate the name of doctor and address of the clinic / hospital and attached copy of the referral letter, if any:

12. Who was the doctor who first diagnosed the patient for this illness? Please provide name and address of the doctor :
.....
13. According to the patient:
 - i. What were the symptoms complained?
 - ii. How long had he/she been experiencing these symptoms?
 - iii. Did the patient already know or aware he/she has this diagnosis before the first consultation with you? Yes No
 - a. Since when? (dd/mm/yyyy)
 - iv. Has the patient previously received any treatment for the above symptom/diagnosis? Yes No
 - a. If yes, please furnish name and address of the doctor
.....
 - b. Date of last treatment the patient received before first consultation with you:(dd/mm/yyyy)
 - c. Type of treatments the patient received upon first diagnosed of this illness:
14. Was the condition: Congenital Hereditary Alcohol Nervous Attempt Suicide Self-Inflicted
 AIDS / HIV Drug Abuse Cosmetic Mental Sexually Transmitted Disease
15. Whether admission due to accident? If Yes:
 - a) When did it occur: (dd/mm/yyyy) Time:(am/pm)
 - b) Nature and details of accident:
 - c) Injury (ies) sustained:

16. Any surgery / procedure performed? Yes No

If yes, please state type of surgery / procedure performed.

Type of surgery / procedure	Date (dd/mm/yyyy)	Name of Doctor & hospital

17. Nature of medical treatment given:

.....

18. Any possibility of relapse? Yes No

19. Has the patient previously been treated or hospitalized in this hospital or other hospital for any other disease? Yes No

If yes, please state

Date (dd/mm/yyyy)	Diagnosis	Name of Doctor & Hospital

20. Has the patient been diagnosed to have High Blood Pressure and / or Diabetes? If yes, please state the recorded blood pressure or blood glucose taken on him / her starting from the first recording done:

Date (dd/mm/yyyy)	Readings of Blood Pressure	Results for Blood Glucose (Fasting's)

21. For female only – was the patient pregnant at the time of hospitalisation? Yes No

i. If so, for how many weeks?

ii. Was illness caused directly or indirectly by: pregnancy child birth caesarian abortion miscarriage
 Infertility and all complications arising therefrom?

If yes, please elaborate:

DECLARATION

I hereby certify that I have personally examined and treated the patient for his / her illness / injury / condition describe above and that the facts stated above are all true to the best of my knowledge and complete. I declare that I have not withheld any material information / fact. The above information is correct as per record from the clinic / hospital.

Signature of Attending Doctor : _____

Name & Qualification of Doctor : _____

Telephone Number : _____

Facsimile Number : _____

Date : _____

Name & address of hospital / clinic : _____

Official stamp of Hospital / clinic : _____