

DISCHARGE MEDICAL REPORT CLAIMS

SECTION I - To be completed by the Insured / Claimant (IN BLOCK LETTERS) SEKSYEN I - Untuk diisi oleh Pihak Diinsuranskan/Pihak Menuntut (DALAM HURUF BESAR)			
Name of Insured <i>Nama Pihak Diinsuranskan</i>		NRIC No. <i>No. K/P</i>	Policy No. <i>No. Polisi</i>
Claimant (other than the Insured) <i>Pihak Menuntut (selain daripada Pihak Diinsuranskan)</i>		Claimant is : <i>Pihak Menuntut ialah :</i> <input type="checkbox"/> Self/Diri Sendiri <input type="checkbox"/> Spouse/Pasangan <input type="checkbox"/> Child/Anak	NRIC No. (if applicable) <i>No. K/P (jika diterima pakai)</i>
Birth Date <i>Tarikh Lahir</i> <input type="text"/> (dd) <input type="text"/> (mm) <input type="text"/> (yy) <i>Tarikh bulan Tahun</i>	Age <i>Umur</i> <input type="text"/>	Sex <i>Jantina</i> <input type="checkbox"/> Male/Lelaki <input type="checkbox"/> Female/Perempuan	Race <i>Bangsa</i>
Religion <i>Agama</i>	Marital Status <i>Status Perkahwinan</i>	Occupation <i>Pekerjaan</i>	
Employer <i>Majikan</i>	Date of Employment <i>Tarikh Mula Bekerja</i>	Employer's Address <i>Alamat Majikan</i>	
Tel. No./No. Tel.			
Type of Claim <i>Jenis Tuntutan</i> <input type="checkbox"/> Hospitalisation/Dimasukkan ke hospital <input type="checkbox"/> Outpatient/Pesakit Luar <input type="checkbox"/> Accident/Kemalangan <i>Circumstances of Accident/Keadaan Kemalangan</i>			
Details of other insurance policies, Socso, Workmen's Compensation and others:- <i>Butir-Butir insuran lain, Perkeso, Insurans Pampasan Pekerja dan lain-lain:-</i>			
Policy Type <i>Jenis Polisi</i>		Insurance Company <i>Syarikat Insuran</i>	Policy No. <i>No. Polisi</i>
<p>AUTHORISATION TO PHYSICIAN, HOSPITAL OR CLINIC TO RELEASE INFORMATION MEMBERI KEBENARAN KEPADA DOKTOR PERUBATAN, HOSPITAL ATAU KLINIK UNTUK MEMBERI MAKLUMAT</p> <p>I hereby authorise any physician, medical practitioner, hospital or clinic by whom or where I have/my ward has been observed or treated, to give full particulars about my/ward's health including my/ward's whole medical history in respect of this hospitalisation/surgery, to the above insurance company.</p> <p><i>Saya dengan ini memberi kebenaran kepada doktor perubatan, pengamal perubatan, hospital atau klinik yang merawat saya/tanggungannya untuk memberi maklumat-maklumat lengkap berhubung dengan riwayat kesihatan saya/tanggungannya saya termasuk latarbelakang penuh perubatan saya/tanggungannya saya semasa dimasukkan di hospital/menjalani pembedahan kepada syarikat insuran.</i></p>			
Signature of Patient <i>Tandatangan Pesakit</i>		Signature of Insured/Claimant <i>Tandatangan Pihak Diinsuranskan/Pihak Menuntut</i>	Date <i>Tarikh</i>

SECTION II - To be completed by the Attending Doctor (IN BLOCK LETTERS)

MRN No:

Name of Hospital and Address

Name of Patient

NRIC No.

Date and Time of Admission

Date and Time of Discharge

(dd) (mm) (yy) (hrs)

(dd) (mm) (yy) (hrs)

Name of Referring Doctor and Address

Admitting Doctor

Attending Doctors

Speciality

1a. Diagnosis/ICD Coding

1b. Cause and Pathology (if applicable) of the above diagnosis

2a. When did patient first consult you for this condition?

(dd) (mm) (yy)

2b. Was the patient previously treated for this condition?

No Yes, give details and when

(dd) (mm) (yy)

2c. How long in your professional opinion has the condition existed?

(dd) (mm) (yy)

3. Any possibility of a relapse?

Yes No

6. Was the patient pregnant at the time of hospitalisation? (For Females Only)

No Yes.....months

7. If the hospitalisation was due to accident, please indicate date/time of accident :

(dd) (mm) (yy) (hrs)

8. Discharge/Follow-up instructions

4a. Please ✓ Nature of Treatment and Investigation:

- OPERATION PHYSIOTHERAPY
 DIETARY COUNSELLING MEDICATIONS
 X-RAY BLOOD TESTS
 OTHERS, give details.....

4b. If more than one procedure was involved, please state Type of Procedures performed :

TYPE DATE NAME OF DOCTOR

i.

ii.

iii.

4c. Other medical conditions present?

Since (dd mm yy).....

Since (dd mm yy).....

Since (dd mm yy).....

5. Was the condition

congenital nervous mental

Signature and Name of Attending Doctor

Hospital Stamp

Date