

## 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	
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><b>AUTHORISATION TO PHYSICIAN, HOSPITAL OR CLINIC TO RELEASE INFORMATION</b>  <b>MEMBERI KEBENARAN KEPADA DOKTOR PERUBATAN, HOSPITAL ATAU KLINIK UNTUK MEMBERI MAKLUMAT</b></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 termasuk latarbelakang penuh perubatan saya/tanggungannya 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

4a. Please  Nature of Treatment and Investigation:

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

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

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

<u>TYPE</u>	<u>DATE</u>	<u>NAME OF DOCTOR</u>
i.		
ii.		
iii.		

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)

4c. Other medical conditions present?

Since (dd mm yy) .....

Since (dd mm yy) .....

Since (dd mm yy) .....

3. Any possibility of a relapse?

Yes  No

5. Was the condition

congenital  nervous  mental

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

Signature and Name of Attending Doctor

Hospital Stamp

Date