HOSPITALISATION BENEFIT (HB) - 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 Participant.
2. Expenses incurred to obtain this report will be borne by the Participant.

Contract 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. 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 investigations, tests or procedures been performed? ☐ Yes ☐ No
    i. If so, what were the results?……
    ii. Please furnish a certified true copy of the results
11. Was the patient referred to you by any doctor? ☐ Yes ☐ No
    i. If yes, please indicate the name of doctor and address of the clinic / hospital.

       ……
    ii. Please attach a 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
    ☐ AIDS/HIV ☐ Drug Abuse ☐ Cosmetic ☐ Mental ☐ Sexually Transmitted Disease

15. Any surgery/procedure performed? Yes No

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

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

16. Nature of medical treatment given ……..

17. Any possibility of relapse? ☐ Yes ☐ No

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

i. If yes, please state

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

19. If the patient was diagnosed to have High Blood Pressure and / or Diabetes, please state the recorded blood pressure or diabetes taken on him/ her starting from the first recording done :

Date (dd/mm/yyyy)	Readings of Blood Pressure	Date (dd/mm/yyyy)	Results for Blood Glucose (Fasting)
i. ……	……..	i. ……	……..
ii. ……	……..	ii. ……	……..
iii. ……	……..	iii. ……..	……..

20. 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? ☐ Yes ☐ No

If yes, please elaborate : ……

DECLARATION

I hereby declare that the foregoing answers and statements are complete and true to the best of my knowledge and belief and that I have withheld no material fact from the Company. I also hereby certify that the above information is correct as per record from the hospital / clinic.

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Signature of Consultant Neurologist

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Name of Consultant Neurologist

Professional Qualification: ……..……..

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Clinic / Hospital Stamp:

Date: ……..……

Tel. No:……..