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.

Policy 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: ……

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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 (Fastings)

21. For female only – was the patient pregnant at the time of hospitalization? ☐ 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 :_____