

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 :

<u>Date (dd/mm/yyyy)</u>	<u>Readings of Blood Pressure</u>	<u>Date (dd/mm/yyyy)</u>	<u>Results for Blood Glucose (Fasting)</u>
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.

Signature of Doctor : _____

Name of Doctor : _____

Telephone No. : _____

Date : _____ (dd/mm/yyyy)

Official Stamp of Doctor :

Qualification : _____

Fax No. : _____

Name and Address of Clinic / Hospital Official Stamp