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MEDICAL REPORT ON COMPREHENSIVE ACCIDENT BENEFIT CLAIM

Policy/Contract/Certificate No. : ___________________________________

Note : **To be completed by the Attending Physician / Surgeon at the claimant's expense.**

SECTION A : PATIENT'S PARTICULARS

1. Name of patient

2. NRIC number (new) ☐☐☐☐☐☐ – ☐☐ – ☐☐☐☐

3. Other identification number

4. Age ☐☐ years old

5. Gender ☐ Male ☐ Female

6. Date of Birth D D – M M – Y Y Y Y

7. Occupation

SECTION B : ACCIDENT & TRATMENT DETAILS

1. (a) Accident Date : D D – M M – Y Y Y Y (b) Time of Accident : H H : M M am / pm
2. Place of Accident : ____________________
3. Nature of Accident : ____________________
4. Injuries Sustained : ____________________
5. Was the patient under the influence of alcohol / drugs? ☐ Yes ☐ No
   If yes, please give details. ____________________
6. Is the condition due to self-inflicted / attempted suicide? ☐ Yes ☐ No
   If yes, please elaborate. ____________________
7. Date of first consultation : D D – M M – Y Y Y Y
8. Did the patient seek treatment for the above prior seeing you? ☐ Yes ☐ No
   If yes, please give details. (a) Date : D D – M M – Y Y Y Y
   (b) Clinic / Hospital : ____________________
9. Are the patient's injuries solely caused by this accident? ☐ Yes ☐ No
   If no, please elaborate. ____________________
10. Was the patient referred to you by any other doctor? ☐ Yes ☐ No
    If yes, please give details.
    (a) Referral Date : D D – M M – Y Y Y Y
    (b) Referral Doctor : ____________________
    (c) Clinic / Hospital : ____________________
    (d) Referral Reason : ____________________
11. For FEMALE patient only.
    (a) Was the patient pregnant at the time of the accident? ☐ Yes ☐ No
    If yes, how many months? ☐☐ months
    (b) Was the patient's condition / accident related directly or indirectly to pregnancy / childbirth? ☐ Yes ☐ No
12. Was the patient hospitalized? ☐ Yes ☐ No
    (a) Admission Date : D D – M M – Y Y Y Y (b) Discharge Date : D D – M M – Y Y Y Y
    (c) Full Diagnosis : ____________________
    (d) Diagnosis Date : D D – M M – Y Y Y Y
13. Was there any surgery performed? ☐ Yes ☐ No
    If yes, please give details.
    (a) Surgery Date : D D – M M – Y Y Y Y
    (b) Type of surgery performed : ____________________
    (c) Please describe the nature / parts / reason for the surgery to be performed.
    ____

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14. Has any investigations, tests or procedures been done? ☐ Yes ☐ No

If yes, please give details. ______________________________

Date	Investigations / Tests / Procedures	Results

15. Was the patient's accident directly or indirectly caused by the following :

		Remarks
(a) Entering, operating or servicing, ascending or descending from or with any aerial device or conveyance except while in an aircraft operated by a commercial passenger airline on a regular schedule passenger trip over its established passenger route?	☐ Yes ☐ No	
(b) Involvement in a breach of law (unless as an innocent party) or activities of an illegal organization?	☐ Yes ☐ No	
(c) Any form of racing or professional / hazardeous sports?	☐ Yes ☐ No	

16. Please give details of ALL consultation and treatment given.

Date	Treatment Details	Healing Progress

17. For fracture(s), where is/are the fracture(s) located? Please state type of fracture and treatment given.

☐ Close fracture ☐ Open fracture ☐ Others (*please specify*) : ______________________________

(a) Area of fracture : ______________________________

(b) Treatment Given : ______________________________

(c) If the patient is put on POP, kindly provide details of the following :

(i) Date POP application : D D – M M – Y Y Y Y

(ii) Date POP removal : D D – M M – Y Y Y Y

(iii) Date physiotherapy started : D D – M M – Y Y Y Y

(iv) Date patient started on full weight bearing exercise (if any) : D D – M M – Y Y Y Y

(v) Was there any limitation of movement at any joint on the last day of treatment? ☐ Yes ☐ No

If yes, please elaborate. ______________________________

18. Was there any amputation / dismemberment involved? ☐ Yes ☐ No

(a) Amputation Date : D D – M M – Y Y Y Y

(b) Area of amputation : ______________________________

(c) Level of amputation : ______________________________

19. Is the patient's disablement : Remarks

(a) Partial ☐ Total ☐ ______________________________

(b) Temporary ☐ Permanent ☐ ______________________________

20. Date of last follow-up : D D – M M – Y Y Y Y

21. Was the patient given medical leave? ☐ Yes ☐ No

Medical leave from : D D – M M – Y Y Y Y To : D D – M M – Y Y Y Y

22. Was the patient put on light duty? ☐ Yes ☐ No

Light duty from : D D – M M – Y Y Y Y To : D D – M M – Y Y Y Y

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SECTION D : MEDICAL HISTORY

1. Does the patient have any of the following conditions? **Treating Clinic / Hospital**

Condition					Since when?	Treating Clinic / Hospital
(a) Hypertension	☐	No	☐	Yes	; since when? ____________	____________
(b) Diabetes Mellitus	☐	No	☐	Yes	; since when? ____________	____________
(c) Dyslipidaemia	☐	No	☐	Yes	; since when? ____________	____________
(d) Heart Disease	☐	No	☐	Yes	; since when? ____________	____________
(e) Kidney Disease	☐	No	☐	Yes	; since when? ____________	____________
(f) Liver Disease	☐	No	☐	Yes	; since when? ____________	____________

2. Does the patient have any other medical conditions or past medical history? ☐ **Yes** ☐ **No**

If yes, please give details.

Diagnosis	Onset Date	Treating Clinic / Hospital

3. If the patient was treated by any other doctor, please give details.

Diagnosis	Doctor's Name	Clinic / Hospital

4. Any further information which in your opinion will assist us in assessing the claim.

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SECTION E : ATTENDING DOCTOR'S DECLARATION

I hereby certify that :

☐ I am the above named patient's attending doctor and I have personally examined and treated him/her for the illness/injuries sustained; **OR**

☐ I have personally perused the above named patient's medical record;

and that the facts as stated above are all true to the best of my knowledge and information that I have perused and that no material fact has been withheld from the Company.

____________________ [ ] **Date :** D D – M M – Y Y Y Y

Signature **Official Hospital Stamp**

Full Name : ______________________________

Hospital / Clinic : ______________________________

Telephone No. : ______________________________

Address : ______________________________

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