PRUPARENT/PRUHOSPITAL INCOME ROOM & BOARD/SURGICAL BENEFIT MEDICAL REPORT FORM

(To be completed by Medical Attendant)

Policy Number

Part 1 – Medical Information

1. Name of Patient
2. NRIC Number
3. Is this condition due to an illness or an accident? Illness ☐ Accident ☐
4. Date of diagnosis of illness /Date of accident
5. Diagnosis of the illness / injury
6. Cause of illness / injury
7. Is this a job-related injury? Yes ☐ No ☐

   If yes, please give details.
8. Date you were first consulted for the injury / illness.
9. Main complaints at this first consultation. If treatment is due to injury, please provide details on nature and extent of injuries sustained
10. Has the patient been treated previously for this condition? Yes ☐ No ☐

    a. If yes, please state when.

    b. Please indicate approximate date from which the patient first noticed symptoms of condition.

    c. In your view, if the condition existed before symptoms became apparent to the patient, please indicate when this condition began to develop.

11. Details of any permanent disability the patient sustained as a result of the illness / injury

12. Is the above condition associated with the following:

a.	Any condition resulting from pregnancy, childbirth or miscarriage or abortion	Yes ☐	No ☐
b.	Any form of dental care of surgery	Yes ☐	No ☐
c.	Any treatment for obesity, weight management program	Yes ☐	No ☐
d.	Eye test, refractive errors of eyes, photo refractive keratectomy, cosmetic or plastic surgery and the provision of appliances, including spectacles lenses, hearing aids, artificial organs or joints, wheelchairs and prosthesis	Yes ☐	No ☐
e.	Any elective surgery, cosmetic or plastic surgery	Yes ☐	No ☐
f.	Routine health check-up, custodial or rest care	Yes ☐	No ☐
g.	Mental illness and psychiatric disorders	Yes ☐	No ☐
h.	Infertility, contraception, sterilisation, circumcision	Yes ☐	No ☐
i.	Human Immunodeficiency Virus infection, AIDS or any sexually transmitted diseases	Yes ☐	No ☐
j.	Birth defect or congenital anomalies	Yes ☐	No ☐
k.	Alcohol, drug abuse or the use of unprescribed drugs where such drugs are required by law to be prescribed by a registered doctor	Yes ☐	No ☐
l.	Participation as a professional in competitive sports	Yes ☐	No ☐
m.	Self-inflicted injury e.g. voluntary causing hurt, attempt suicide, participating in hazardous activity (e.g. scuba diving, bungee-jumping, mountaineering)	Yes ☐	No ☐

13. If your answer to any of the conditions listed under Question 12 is "Yes", please provide details.

Part 2 – Hospitalisation Room & Board

2.1. Name of hospital patient was admitted to:

2.2. Please indicate how the patient was admitted:

☐ Emergency admission

☐ Referral by a doctor
Please provide Doctor's name and address

2.3. Date and time of admission:

2.4. Date and time of discharge:

2.5. Date of medical leave

Part 3 – Surgical Procedure

3.1. Were surgical procedures performed on the patient? Yes ☐ No ☐

If your answer is " Yes ", please put a tick in the box alongside the categories of procedures listed below:

a.	☐	Skin	h.	☐	Male Genital System
b.	☐	Musculoskeletal System	i.	☐	Female Reproductive System
c.	☐	Respiratory System	j.	☐	Endocrine System
d.	☐	Cardiovascular System	k.	☐	Nervous System
e.	☐	Haemic & Lymphatic System	l.	☐	Eye
f.	☐	Digestive System	m.	☐	Ear / Nose / Throat
g.	☐	Urinary System	n.	☐	Endoscopies

3.2. Please describe in detail the surgical operation(s) performed on the patient.

3.3. Please state the objective(s) of the operation(s)

3.4. If 2 or more of the surgical procedures were performed, were they performed under the same anaesthesia?

Yes ☐ No ☐

If your answer is **"No"**, please give details.

3.5. Date of surgical operation(s)

3.6. Is patient still under your care for this condition?

Yes ☐ No ☐

If 'No', please give date of last consultation.

3.7. If no surgery was performed, was surgery advised?

Yes ☐ No ☐

If 'Yes', please give reasons why patient did not proceed with the surgery.

Part 4 – Reference

4.1. Name and Address of doctor(s) previously consulted by patient for this condition

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I hereby certify that the answers given are complete, full and true to the best of my knowledge.

Signature

Name

Date

Practice Stamp