

## DISCHARGE MEDICAL REPORT FORM BORANG TUNTUTAN HOSPITAL

The issue of this form is NOT an admission of liability on the part of the Company./  
 Pengeluaran borang ini tidak bermakna tanggungan pihak Syarikat telah diakui.

**SECTION I – To be completed by the Insured / Claimant (IN BLOCK LETTERS)**
**SEKSYEN I – Untuk diisi oleh Pihak Diinsuranskan / Pihak Menuntut (DALAM HURUF BESAR)**

		NRIC No./ No. K/P	Policy No./ No. Polisi	
Claimant (other than the Insured) / Pihak Menuntut (selain daripada Pihak Diinsuranskan)		Claimant / Pihak Menuntut: <input type="checkbox"/> Self / Diri Sendiri <input type="checkbox"/> Spouse / Pasangan <input type="checkbox"/> Child / Anak		NRIC No. / No. K/P (if applicable / jika berkaitan)
Birth Date / Tarikh Lahir <input type="text"/> (dd) <input type="text"/> (mm) <input type="text"/> (yy) Tarikh      Bulan      Tahun	Age / Umur	Sex / Jantina <input type="checkbox"/> Male / Lelaki <input type="checkbox"/> Female / Perempuan	Race / Bangsa	Religion / Agama
Marital Status / Status Perkahwinan	Occupation / Pekerjaan	Date of Employment / Tarikh mula bekerja		
Employers Name, Address & Telephone No. / Nama, Alamat & No. Telefon Majikan	Date patient joined the Insurance Scheme / Tarikh pesakit menyertai Skim Insurans		Insurance's Plan No. / No. Pelan Insurans	
	Claims Payment should be made payable to / Tuntutan pembayaran harus dibuat kepada <input type="checkbox"/> Employer/ Majikan <input type="checkbox"/> Employee / Pekerja <input type="checkbox"/> Hospital/ Hospital			
Type of Claim (Please tick where applicable) / Jenis Tuntutan (Sila tandakan yang berkaitan)				
<input type="checkbox"/> Hospitalisation / Dimasukkan ke hospital <input type="checkbox"/> Outpatient / Pesakit Luar <input type="checkbox"/> Accident / Kemalangan				
If injuries are due to accident, please describe how the accident occurred. / Jika kecederaan disebabkan oleh kemalangan, sila terangkan bagaimana kemalangan berlaku. ..... .....				
Details of other insurance policies, Socso, Workmen's Compensation and others: (please use a separate sheet if necessary) Butir-Butir insurans lain, Perkeso, Insurans Pampasan Pekerja dan lain-lain: (Jika perlu, sila tulis dalam lampiran berasingan)				
Policy Type / Jenis Polisi	Period of Cover / Tempoh Perlindungan	Insurance Company / Syarikat Insurans	Policy No. / No. Polisi	

**AUTHORISATION TO PHYSICIAN, HOSPITAL OR CLINIC TO RELEASE INFORMATION & DOCUMENTS /**

**MEMBERI KEBENARAN KEPADA DOKTOR PERUBATAN, HOSPITAL ATAU KLINIK UNTUK MEMBERI MAKLUMAT & DOKUMEN**

I hereby authorise any physician, medical practitioner, hospital or clinic by whom or where I have / my ward has been observed or treated, to give full particulars about my / ward's health including my / ward's whole medical history in respect of this hospitalisation / surgery, to the above insurance company. /

Saya dengan ini memberi kebenaran kepada doktor perubatan, pengamal perubatan, hospital atau klinik yang merawat saya / tanggungan saya untuk memberi maklumat-maklumat lengkap berhubung dengan riwayat kesihatan saya / tanggungan saya termasuk latar belakang penuh perubatan saya/tanggungan saya semasa dimasukkan di hospital / menjalani pembedahan kepada syarikat insurans.

.....  
Signature of Patient /  
Tandatangan Pesakit

.....  
Signature of Insured & Company Chop /  
Tandatangan Pihak Diinsuranskan/Pihak Menuntut &  
Chop Syarikat

.....  
Date / Tarikh

**SECTION II – To be completed by the Attending Doctor (IN BLOCK LETTERS)**

**MRN No:**

Name of Hospital and Address

Name of Patient

NRIC No.

Date and Time of Admission

(dd)  (mm)  (yy)  (hrs)

Date and Time of Discharge

(dd)  (mm)  (yy)  (hrs)

Name of Referring Doctor and Address

Admitting Doctor

Attending Doctors

Speciality

1a. Diagnosis / ICD Coding

1b. Cause and Pathology (if applicable)  
of the above diagnosis

4a. Please  Nature of Treatment and Investigation:

- OPERATION  PHYSIOTHERAPY DIETARY  
 COUNSELLING  MEDICATIONS  
 X-RAY  BLOOD TESTS  
 OTHERS (Please provide details)

4b. Please state the surgical procedures performed.  
If more than one procedure was involved, please state Type of  
Procedures performed:

TYPE DATE NAME OF DOCTOR

i.

ii.

iii.

4c. Other medical conditions present?

Since (dd /mm/ yy)

Since (dd /mm /yy)

2a. When did patient first consult you for this condition?

(dd)  (mm)  (yy)

2b. Was the patient previously treated for this condition?

No  Yes, please provide details and when

(dd)  (mm)  (yy)

2c. How long in your professional opinion has the condition existed?

(dd)  (mm)  (yy)

3. Any possibility of a relapse?

Yes  No

5. Was the condition

congenital  nervous  mental

6. Was the patient pregnant at the time of hospitalisation? (For Females Only)

No  Yes .....months

7. If the hospitalisation was due to accident, please indicate date / time of accident:

(dd) (mm) (yy) (hrs)

8. Discharge / Follow-up instructions

.....  
Signature and Name of Attending Doctor

.....  
Hospital Stamp

.....  
Date