MPI GENERALI

MPI Generali Insurans Berhad (14730-X)

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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:* ☐ Self / *Diri Sendiri* ☐ Spouse / *Pasangan* ☐ Child / *Anak*	NRIC No. / No. K/P (if applicable / *jika berkaitan*)

Birth Date / *Tarikh Lahir*	Age / *Umur*	Sex / *Jantina*	Race / *Bangsa*	Religion / *Agama*
☐ (dd) *Tarikh* ☐ (mm) *Bulan* ☐ (yy) *Tahun*		☐ Male / *Lelaki* ☐ Female / *Perempuan*		

Marital Status / *Status Perkahwinan*	Occupation / *Pekerjaan*	Date of Employement / *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*

☐ Employer/ *Majikan* ☐ Employee / *Pekerja* ☐ Hospital/ *Hospital*

Type of Claim (Please tick where applicable) /
Jenis Tuntutan (Sila tandakan yang berkaitan)

☐ Hospitalisation / *Dimasukkan ke hospital* ☐ Outpatient / *Pesakit Luar* ☐ Accident / *Kemalangan*

If injuries are due to accident, please describe how the accident occurred. /
Jika kecederaan disebabkan oleh kemalangan, sila terangkan bagaimana kemalangan berlaku.

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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

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

4a. Please ☑ Nature of Treatment and Investigation:

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

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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)

……

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