Medical Report

(To be completed by Attending Physician / Surgeon)

TOKIO MARINE
INSURANCE GROUP

1. a. Patient's Name: _____ b. Age: _____

   c. NRIC: _____ d. Gender: ☐ Male ☐ Female

2. This report is regarding of patient's: ☐ Admission ☐ Day Care Surgery ☐ Others, please specify: _____

3. Admission Date and Time: ☐☐☐☐☐☐☐☐ (D D M M Y Y Y Y) (Time) _____ ☐ am ☐ pm

4. Discharge Date and Time: ☐☐☐☐☐☐☐☐ (D D M M Y Y Y Y) (Time) _____ ☐ am ☐ pm

5. a. Symptoms / Conditions requiring admission: _____

   b. Patient's BP / Temp. / Pulse: _____

   c. How long is patient aware of the condition: _____

   d. Date symptoms first appeared: ☐☐☐☐☐☐☐☐ (D D M M Y Y Y Y)

   e. Date first consulted: ☐☐☐☐☐☐☐☐ (D D M M Y Y Y Y)

6. a. Any previous consultation / treatment / hospitalisation for this symptom / illness or related conditions, or other disorders whether in this hospital or any other facilities? ☐ Yes ☐ No

   Name and Address of doctors previously consulted by the patient for the condition:

   _____

   _____

   b. Was this patient referred to you? If yes, please provide details below:

   _____

   c. If this condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed:

   _____

   d. Can the condition be managed under the Outpatient basis: ☐ Yes ☐ No
   If no, please provide reasons of admission:

   _____

7. a. Final Diagnosis: _____

   b. Cause and pathology underlying the present diagnosis: _____

   _____

   c. Any possibility of relapse: ☐ Yes ☐ No
   Is follow up required? ☐ Yes ☐ No

8. Is the illness / condition related to (please tick (✓) if YES):

   ☐ Pregnancy / Childbirth / Infertility / Caesarean Section / Miscarriage or any complications arising therefrom
   ☐ Congenital / Hereditary Diseases
   ☐ Influence of Drugs / Alcohol
   ☐ Nervous / Mental / Emotional / Sleeping Disorder
   ☐ Cosmetic Reason / Dental Care / Refractive Errors Correction
   ☐ AIDS / STD / VD / HIV
   ☐ Self-inflicted Injuries / Violation of Laws / Strike / Riots
   ☐ None of the above

   Please provide details:

   _____

   _____

Tokio Marine Insurans (Malaysia) Berhad
198601000381 (149520-U)
Level 20, Menara Hap Seng 3, Plaza Hap Seng, No. 1, Jalan P. Ramlee, 50250 Kuala Lumpur, Malaysia.
T: (03) 2027 8200 / 2789 8800 F: (03) 2022 2295 Customer Service Hotline: 1800 88 0812
tokiomarine.com

9. a. Treatment given / investigation done (please supply copy of all investigation results):

_____

_____

b. Surgical procedures performed: _____

c. MMA code / PHFSR code: _____

d. Date of surgery / procedure: D D M M Y Y Y Y

10. Any other medical / surgical conditions present: ☐ Yes, details below ☐ No

a. _____

b. _____

11. a. Was the patient pregnant at the time of hospitalisation? (For Female only) ☐ Yes, _____ months ☐ No

b. Was the illness caused directly or indirectly by pregnancy/child birth/caesarian section/ abortion miscarriage and all complications arising therefrom? ☐ Yes, details below ☐ No

_____

12. a. If hospitalisation was due to injury, please describe circumstances and cause of injury: ☐ Yes, details below ☐ No

_____

b. Please indicate date/time of accident: D D M M Y Y Y Y (Time) _____ ☐ am ☐ pm

13. In the case of DEATH, please advise Date/Time and Cause of death:

_____

_____

14. I hereby certify that I have personally examined and treated the Patient for his/her injury/illness described above and that the facts as stated above represent my medical opinion of his/her condition.

Date	Name & Signature of Attending Doctor	Doctor / Hospital Stamp