Anzen Health
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# ATTENDING PHYSICIAN'S STATEMENT FORM

| PATIENT ADMISSION DETAILS | |
|---|---|
| PATIENT NAME | COMPANY NAME |
| PATIENT ID (NRIC/ PASSPORT) | HOSPITAL NAME |
| MRN/ ADMISSION NUMBER | ADMISSION DATE AND TIME |
| DATE OF BIRTH/ AGE | SPECIALIST/ PHYSICIAN'S NAME |

## SECTION 1: ADMISSION DETAILS

1. a) Please confirm admission reason

☐ Surgical ☐ Medical ☐ Accident ☐ Delivery

b) Additonal admission reason remarks

_____

2. a) If admission as due to accident, please confirm the date and details of the accident

Date and time of accident

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b) Elaborate the detail of the accident

_____

_____

3. a) Was the patient pregnant during the hospitalisation?

☐ Yes ☐ No

b) If 'YES', please state the gestation period ☐☐ weeks

4. a) Symptoms/ Condition requiring admission

| Symptom/ Condition Description | Date First Appeared | Date First Consulted |
|---|---|---|
| | | |
| | | |
| | | |

4. b) How long has the patient been aware of the condition?

☐☐ Years ☐☐ Months

c) Patient's blood pressure/ temperature/ pulse

Blood pressure (mmHg) ☐☐☐ Temperature (°C) ☐☐☐ Pulse (BPM) ☐☐☐

5. 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

b) Was the patient referred?

☐ Yes ☐ No

c) If 'YES', please provide the details of patient's referral

_____

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

| Disease/ Disorder | Treatment Detail | Doctor/Hospital/Clinic | Date |
|---|---|---|---|
| | | | |

e) Can the condition be manage under Outpatient basis?

☐ Yes ☐ No

e) If 'NO', please provide the reasons for admission

_____

6. a) Admitting/ Provisional Diagnosis (ICD-10 coding recommended)

| Diagnosis Description | ICD-10 Code | Date Confirmed | Date First Advised |
|---|---|---|---|
| | | | |

b) Cause and pathology underlying the present diagnosis

_____

7. Please confirm if the diagnosis was cause directly or indirectly by the following conditions

- ☐ Pregnancy/Childbirth/Caesarean section/Miscarriage/Prenatal/Postnatal/Sterilisation/Infertility
- ☐ Congenial/Hereditary Disease
- ☐ Influence of Drugs/Alcohol
- ☐ Nervous/Mental/Emotional/Sleeping Disorder
- ☐ Cosmectic surgery/Dental care/Refractive errors connection
- ☐ AIDS/HIV/STD/VD
- ☐ Self-inflicted Injuries/Violation of Laws/Strike/Riots
- ☐ None of the above

8. a) Any other medical / surgical conditions / illnesses present?

☐ Yes ☐ No

a) If 'YES', please elaborate

| Condition / Illness Description | Date First Advised |
|---|---|
| | |

9. a) Treatment plan(s), Invesgation(s) and Surgical procedure(s) to be performed, if any

| Treatment Plan Description | Estimated Cost (RM) | Date (DD/MM/YYYY) |
|---|---|---|
| | | |

b) Estimated day(s) of stay

☐☐ Days

c) Expected discharge date

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**SECTION 2: ATTENDING DOCTOR'S DECLARATION**

I hereby certify that I have personally examined and treated the Patient for the injuries/illness described above and that the facts as stated above represent my medical opinion of their condition

Attending doctor / physician / surgeon's stamp and signature

Name

Date

D D – M M – Y Y Y Y