(IPD ส่วนที่ 2)

บริษัท เจนเนอราลี่ ประกันชีวิต (ไทยแลนด์) จำกัด (มหาชน)

ใบรายงานแพทย์ผู้ตรวจรักษา (Attending Physician's Report)

Patient name……………………………………………………………………Age …………HN#…………………AN#………………….

Admission Date…………………………..Time………………… Discharge Date ……………………………Time………………..

1. Chief Complaint……..

2. FOR ILLNESS

a. How long has the patient experienced the symptoms?...

b. How long do you feel that symptoms existed prior to this consultation?..

3. FOR ACCIDENT

a. Date & Time of accident?.. Caused of accident?...

b. Details of injury ....

c. Was the patient under the influence of alcohol at the time of arrival to the hospital? [ ] No [ ] Yes

4. Pertinent clinical finding (Symtoms & Signs): …………………………………………………………………………………..

5. Did you advise the patient to be admitted in the hospital? [ ] No [ ] Yes; Indication for admission………………………….

………

6. Pertinent lab / investigation……………………………………………………………………………………………………….

…………………………………………………… HIV Test [ ] No [ ] Yes, Result…………………………………………………

7. Treatments (including medication given, surgery , physical therapy, etc.)………………………………………………………

………

8. Diagnosis (including principle / underlying condition / complication)

………

9. Diagnosis and treatment by other doctors in the same occasion. [ ] No [ ] Yes, Please give details……………………….

………

10.a). Result of treatment [ ] Good [ ] Fair [ ] Poor b). Possibility of recurrence [ ] No [ ] Yes

11. Was the illness contribute to congenital anomaly [ ] No [ ] Yes

12. Date and the patient's symptoms of the last treatment / Follow up……………………………………………………………

13. For Female : Was the patient pregnant at the time of treatment? [ ] No [ ] Yes, Specify…………………… weeks/months

14. Other comments about illness/injury………………………………………………………………………………………………

15. Other past medical history:

Date	Diagnosis	Treatment	Duration	Doctor/Hospital's name

I, hereby certify that I have personally examined and treated the insured in connection to the above disability and that to facts are in my opinion as given above

Name of physician……………………………………………Specialty………………………………License No…………………

Signature……………………………………………Date……………………………………Tel………………………………….

กรุณาประทับตราสถานพยาบาล