

**MEDICAL FORM**

Patient: \_\_\_\_\_ Hospital: \_\_\_\_\_  
 IC No.: \_\_\_\_\_ Age: \_\_\_\_\_ Officer-in-charge \_\_\_\_\_ Tel No \_\_\_\_\_ Fax No \_\_\_\_\_  
 Membership No.: \_\_\_\_\_ Date of Admission \_\_\_\_\_ Time \_\_\_\_\_  
 Patient Tel. No.: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_ Time \_\_\_\_\_

**PART 1 - ADMISSION**

1 Is the patient referred to you? Yes / No If yes, please fax referral letter to MediExpress.  
 2 Is this admission due to an accident? Yes / No  
 Nature of accident: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
 3 Presenting symptoms: \_\_\_\_\_ since: \_\_\_\_\_  
 4 Provisional diagnosis: \_\_\_\_\_  
 \_\_\_\_\_  
 5 Has this illness / accident occurred before? Yes / No If yes, when did it first occurred? \_\_\_\_\_  
 6 Is there any condition / illness that caused or is related to the present illness: Yes / No  
 If yes, pls specify: \_\_\_\_\_ since: \_\_\_\_\_  
 7 Has the patient ever had any of the following illness/condition?  
 (a) Hyperlipidemia Yes / No since \_\_\_\_\_  
 (b) Hypertension Yes / No since \_\_\_\_\_  
 (c) Diabetes Yes / No since \_\_\_\_\_  
 (d) Heart disease Yes / No since \_\_\_\_\_  
 (pls specify: \_\_\_\_\_)  
 (e) Stroke / TIA / Epilepsy Yes / No since \_\_\_\_\_  
 (f) SLE / Rheumatoid arthritis Yes / No since \_\_\_\_\_  
 (g) Cancer / Tumour Yes / No since \_\_\_\_\_  
 (pls specify: \_\_\_\_\_)  
 (h) HIV / AIDS & its complication Yes / No since \_\_\_\_\_  
 (i) Any other serious illness Yes / No since \_\_\_\_\_  
 (pls specify: \_\_\_\_\_)  
 8 Is the present illness:  
 (a) congenital Yes / No  
 (b) hereditary Yes / No  
 (c) a psychiatric disorder Yes / No  
 (d) pregnancy related Yes / No  
 (e) infertility related Yes / No  
 (f) self-inflicted injury Yes / No  
 (g) due to alcohol/drugs abuse Yes / No  
 (h) STD Yes / No  
 (i) treated for cosmetic reason Yes / No  
 9 Investigation required: \_\_\_\_\_  
 10 Procedures / treatment required : \_\_\_\_\_  
 I hereby certify that the above information is true and correct  
 \_\_\_\_\_  
 Date \_\_\_\_\_ Name of Doctor \_\_\_\_\_ Signature of Dr with Stamp \_\_\_\_\_ Hospital stamp \_\_\_\_\_

**PART 2 - DISCHARGE**

1 Final diagnosis: \_\_\_\_\_  
 \_\_\_\_\_  
 2 Results of investigations: \_\_\_\_\_  
 \_\_\_\_\_  
 3 Surgery / Procedure done: \_\_\_\_\_  
 \_\_\_\_\_  
 4 Treatment / medication: \_\_\_\_\_  
 5 Is condition likely to recur? Yes / No 6 Is follow-up required? Yes / No  
 7 Medical report has also been issued to: \_\_\_\_\_  
 \_\_\_\_\_  
 Date \_\_\_\_\_ Doctor \_\_\_\_\_ Signature \_\_\_\_\_

**PART 3 - PATIENT / GUARDIAN CONSENT**

I hereby authorize any physician, nurse, medical staff, hospital or clinic by whom I or the abovenamed have been observed or treated, to release any medical information and investigation results including past medical history to MediExpress (Malaysia) Sdn Bhd and the insurer in order to process the insurance claims. I hereby undertake to reimburse MediExpress (Malaysia) Sdn Bhd in the event that the hospitalization costs are not covered by the policy due to any reason whatsoever.

Date \_\_\_\_\_ Name \_\_\_\_\_ Relationship \_\_\_\_\_ Signature \_\_\_\_\_