

Physician's Report

Physician issuing this report must be the physician having the Doctor of Medicine degree and license in the practice of medicine. In case there is any fee, the insured shall take responsibility for such fee.

Patient's Name..... ID Card No

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Sex : Male Female H.N.#..... A.N.#..... X.N.#.....

Consultation Date.....(OPD case) or Admission Date Time Discharge Date Time.....

For illness :

1. Date you first saw this patient for this illness ?.....
2. Chief complaint and duration of symptoms
3. In your opinion, how long should these symptoms persist for this illness.....

For Injury:

1. Date & Time of injury..... Date & Time you first saw this patient.....
2. Cause of injury.....
3. (Did you smell alcohol from the patient) ได้กลิ่นสุราจากผู้ป่วยหรือไม่ No Yes Not known
 Level of consciousness Normal Confusion Drowsiness Semi-coma Coma
 (Did the patient take any medication, drugs?) ผู้ป่วยกินยามาหรือไม่ No Yes (ชื่อ/ชนิด ของยา.....) Not known

Pertinent Clinical findings (Symptoms & Signs) / nature of wound and injured organs.....

Past History / Underlying diseases.....

Investigations.....

Diagnosis 1..... ICD10..... Diagnosis 2..... ICD10.....

Diagnosis 3..... ICD10..... Diagnosis 4..... ICD10.....

Treatment.....

Surgery/Operation..... ICD-9CM or 10TM..... Date performed.....

Anesthesia type : GA LA..... Pathology report.....

Result / Complications.....

Is the illness related to alcohol , drug abuse or addiction ? No Yes

For Female : Was the patient pregnant at the time of treatment? No Yeswks (LMP.....)

Was the treatment related to infertility ? No Yes

HIV test Not done Done Result

Has the patient ever been treated by other doctors before? No Yes, please give name and address.....

Was the injury/illness contributed to or influenced by any of the following (e.g. Pre-existing weakness or extened period of disability)?

- | | | |
|---|-----------------------------|------------------------------|
| a) Physical defects/congenital anomaly | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| b) Unfavorable past medical history | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| c) Degenerative change (s) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| d) A family history that increased the probability or severity of this disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| e) Doctor's advice to have periodic " Medical Screening " for this disease of increased risk ? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

If the answer is " **yes** " , please specify

Other past medical history :

Date	Sign & Symptom	Diagnosis	Treatment	Doctor / Hospital's Name

Other comments about the injury / illness.....

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

Name of physician..... Specialty..... License No.....

Hospital Name..... Address..... Telephone No.....

Signature..... Date

(.....)

Remark: Whoever, in the pursuance of work in the medicine, makes the false certification or document by the manner likely to cause injury to the other persons or people, that person commits the offence according to the Panel Code and shall be imprisoned not out of two years or fined not out of four thousand Baht or both, and shall compensate for a civil penalty.