

SEKSYEN II - Discharge Medical Report Form

To be completed by the Attending Doctor (IN BLOCK LETTERS)

MNR No:

Name of Hospital and Address

Name of patient

NRIC No.

Date and Time of Admission

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d d m m y y y y

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(hrs)

Date and Time of Discharge

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d d m m y y y y

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(hrs)

Name of Referring Doctor and Address

Admitting Doctor

Attending Doctors

Speciality

1a. Diagnosis / ICD Coding

4a. Please √ Nature of Treatment and Investigation:

- | | |
|---|--|
| <input type="checkbox"/> OPERATION | <input type="checkbox"/> PHYSIOTHERAPY |
| <input type="checkbox"/> DIETARY COUNSELLING | <input type="checkbox"/> MEDICATIONS |
| <input type="checkbox"/> X-RAY | <input type="checkbox"/> BLOOD TESTS |
| <input type="checkbox"/> OTHERS, give details _____ | |

1b. Cause and Pathology (if applicable) of the above diagnosis.

4b. If more than one procedure was involved, please state Type of Procedures performed:

	<u>TYPE</u>	<u>DATE</u>	<u>NAME OF DOCTOR</u>
i.			
ii.			
iii.			

2a. When did patient first consult you for this condition?

 (dd) (mm) (yy)

2b. Was the patient previously treated for this condition? No Yes, give details and when

 (dd) (mm) (yy)

2c. How long in your professional opinion has the condition existed?

 (dd) (mm) (yy)

3. Any possibility of a relapse?

Yes No

5. Was the condition

congenital nervous mental

6. Was the patient pregnant at the time of hospitalisation? (For Females Only)

No Yes, _____ months

7. If the hospitalisation was due to accident, please indicate date / time of accident:

 (dd) (mm) (yy) (hrs)

8. Discharge / Follow-up instructions

Signature and Name of Attending Doctor

Hospital Stamp

Date