Allianz General Insurance Company (Malaysia) Berhad 200601015674 (735426-V)
(Licensed under the Financial Services Act 2013 and regulated by Bank Negara Malaysia)

Allianz

MEDICAL REPORT
(HOSPITALISATION CLAIM)

Patient's Name ______
I/C No ______
Admission __ / __ / ____ Time __ : __
Discharge __ / __ / ____ Time __ : __

(1) Presenting SYMPTOMS at time of Admission
______
since __ / __ / ____

(2) PHYSICAL FINDINGS
______
______

(3) ETIOLOGY of the above diagnosis
______
______

(4) When did patient first consult you for this complaint?
__ / __ / ____

(5) How long, in your opinion has the CONDITION EXISTED?
__ day(s) __ week(s) __ month(s) __ year(s)

(6) Was Patient PREVIOUSLY TREATED for this diagnosis? ☐ Yes ☐ No
If Yes, please advise Date of Treatment __ / __ / ____
and Name & Address of Physician:
______

(7) FINAL DIAGNOSIS
______ Code ______
______ Code ______
______ Code ______

(8) MEDICAL TREATMENT Provided (Please state)
i) ______
ii) ______
iii) ______

(9) SURGICAL PROCEDURE PERFORMED IN CHRONOLOGICAL ORDER
i) ______
ii) ______
iii) ______

(10) Other TREATMENT(S) Provided (Please state)
i) ______
ii) ______

(11) Any possibllity of a RELAPSE ☐ Yes ☐ No

(12) Any COMPLICATIONS developed during hospitalisation?
If YES, kindly elaborate below
______

(13) Any ADDITIONAL Medical Information

(14) MEDICATION dispensed
______
______
______

If this consultation is due to an accident, please state

(15) Injury Sustained
______

(16) Mechanism of Injury
______

(17) Accident Date __ / __ / ____ Time __ : __

(18) Is Hospitalisation required? ☐ Yes ☐ No

(19) This present diagnosis is related to / is

Pregnancy / Childbirth	☐ Yes	☐ No	Alcohol / Drug Abuse	☐ Yes	☐ No
Congenital / Neo-natal	☐ Yes	☐ No	Mental / Anxiety Disorders	☐ Yes	☐ No
HIV / AIDS	☐ Yes	☐ No	Attempted Suicide / Self-Inflicted	☐ Yes	☐ No

(20) Has Patient SUFFERED from / is Patient SUFFERING any illnesses stated below?

Hypertension	☐ No	☐ Yes	since ______
Cardiovascular Disease	☐ No	☐ Yes	since ______
Gastrointestinal Disease	☐ No	☐ Yes	since ______
Malignancy of Any Kind	☐ No	☐ Yes	since ______
Diabetes	☐ No	☐ Yes	since ______

(21) Are OTHER MEDICAL CONDITIONS present (Both Related and Unrelated to Current Diagnosis)?
______ since ______

(22) In the case of DEATH, please advise
Date of Death __ / __ / ____ Time of Death __ : __

(23) CAUSE of Death
______

(24) Due to
______

I, the undersigned hereby declare that the information on this form is true in every respect. I have supplied full information on all particulars relevant to this patient.

______
Signature of Admitting Physician/Surgeon
Date

Mobile Phone Contact No ____ - ________

Email ______

Stamp of Admitting Physician/Surgeon

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