BANGKOKLIFE ASSURANCE

**Part II: Physician Discharge Summary**

Patient's name..... HN : ..... AN: ….....

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: .....

**For Injury:**

1. Date & Time of injury ..... Cause of injury .....

.....

2. Nature of wound and injured organs ….....

.....

3. (Did you smell alcohol from the patient?) ( ) No ( ) Yes, blood alcohol test (if any) =…..... mg%

Level of consciousness ( ) Normal ( ) Confusion ( ) Drowsiness ( ) Semi-coma ( ) Coma

Estimated time for recovery ….....

Did the patient need to be admitted to hospital? ( ) No ( ) Yes,indication for admission .....

Pertinent Clinical findings (*Symptoms & Signs*) .....

Investigations & Result .....

Underlying diseases .....

Diagnosis 1 ….....ICD10-TM.....

Diagnosis 2 ….....ICD10-TM.....

Diagnosis 3 ….....ICD10-TM.....

Treatment .....

Surgery/Operation ..... Date ..... ICD10-TM/ICD9-CM .....

Pathological report ..... Complications (if any) .....

Is the illness related to alcohol, drug abuse or addiction? ( ) No ( ) Yes, please specify .....

For Female : Is the patient pregnant? ( ) No ( ) Yes Gestational age ..... Wks.

Was the treatment related to infertility? ( ) No ( ) Yes .....

HIV ( ) Not done ( ) Done ( ) Result ..... Date performed .....

Has patient ever been treated by other doctor before? ( ) No ( ) Yes, please give name and address .....

Was the illness/injury contributed to or influenced by any of the following

Physical defects/congenital anomaly ( ) No ( ) Yes

Degenerative change(s) ( ) No ( ) Yes

Others past medical history

| *Date* | *Signs & Symptoms* | *Diagnosis* | *Treatment* | *Physicians/Hospital* |
|---|---|---|---|---|
| | | | | |

Other comments about the injury/Illness .....

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

Physician 's signature ..... Medical specialty ..... Medical License No. .....

Medical institute ..... Hospital ..... Date .....