FORM OF DOCTOR STATEMENT For Hospitalization Claim

(Filled by Doctor)

Dedicated to Doctor, _____

Please your willingness to complete the form truly based on existing data and Doctor's knowledge. Thank you.

Patient's Data

Name of Patient :

Date of Birth / Age : _____ / _____ / _____ / or _____years,

Address of Patient :

Patient No. / Medical Record : _____

Gender : ☐ Male ☐ Female

Medical History

Date of first consultation	☐☐ ☐☐ ☐☐☐☐ (date / month / year)
Symptoms and signs of disease/injury	
Diagnosis of disease or injury	
Doctor who did the examination/treatment	

Hospitalization

Date of symptoms/signs first appeared	☐☐ ☐☐ ☐☐☐☐ (date / month / year)
Date of the disease first diagnosed	☐☐ ☐☐ ☐☐☐☐ (date / month / year)
Hospitalization date	From (date/month/year) _____to (date/month/year)_____
First diagnosis	
FINAL DIAGNOSIS*)	
Cause of diagnosis	
Treatment/action given	
Type of surgery (If surgery was done)	Surgery date : ☐☐ ☐☐ ☐☐☐☐ (date/ month/ year) Name of Doctor who done the surgery :
Physical Examination Results	BP: _____ HR :_____ Temperature : ____Respiratory Rate : _____ Consciousness : _____
Supporting examination (Laboratorium, X Ray, EKG, etc. Please attached.	
Did the treatment based on patient's own request ?	☐ YES ☐ NO, Please explain: _____
*)What was the final diagnosis above	
Related to pregnancy (If the patient is female) ?	☐ YES ☐ NO, Please explain: _____
Related to Mentally illness ?	☐ YES ☐ NO, Please explain: _____
Related to congenital disease ?	☐ YES ☐ NO, Please explain: _____
Related to accident ?	☐ YES ☐ NO, Please explain: _____
Chronic disease or recurrent episode ?	☐ YES ☐ NO If Yes, suffered since : ☐☐ ☐☐ ☐☐☐☐ (date/month/year)

Disease History

Do this patient suffered/had history of disease related with Hypertension, Diabetes Mellitus, Heart, Pneumonia, Narcotic, HIV or other diseases ?	☐ YES ☐ NO Diagnosis:_____ Suffered since : _____
Did the patient's treatment related with disease history mentioned above ?	☐ YES ☐ NO If YES, Reason : _____
Did doctor/colleague examine/treat this patient before	☐ YES ☐ NO If YES, When : _____ Diagnosis : _____
Please mention name, address of doctor/hospital that had been visited by this patient	

I hereby declare that I had read, understood and answered the questions above completely and correctly.

Name of Doctor : _____ Specialization : _____

Address of Doctor/Hospital : _____ Phone No. / Handphone : _____

Place & Date	Doctor's signature	Hospital Stamp

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