AXA INSURANCE PTE LTD
8 Shenton Way, #24-01 AXA Tower
Singapore 068811
Customer Care Team
☎ 1800 880 4888
@ customer.care.health@axa.com.sg
www.axa.com.sg
Co. Reg No. 199903512M

Medical Report

Policy No. / Claim No. (if applicable)

To be completed by your treating doctor if you have attended a private hospital or a hospital outside Singapore

1. Name of Patient

2. NRIC / FIN / Passport No.

3. Date admitted (DD/MM/YYYY) _____ Date discharged (DD/MM/YYYY) _____

4. Was Patient referred to you by another doctor? ❑ Yes ❑ No
   If "Yes", please state date of referral and provide us with the name and address of referring doctor.

Date or Referral (DD/MM/YYYY)	Name of Doctor and address of clinic

5. When did patient first consult you for the condition? Date of first consultation (DD/MM/YYYY)

6. Nature of treatment rendered _____ Date of treatment (DD/MM/YYYY) _____

7. What were the complaints or symptoms presented during the first consultation?

8. When did patient first experience these complaints or symptoms? Date of first consultation (DD/MM/YYYY) _____
   If there were no complaints or symptoms, what prompted the patient to see you?

9. In your expert opinion, per history provided to you by patient and given the etiology of the condition, please state the estimated duration of such condition would be in existence for this patient.

10. Has patient received any prior treatment for these complaints or symptoms? ❑ Yes ❑ No
    If "Yes", plese provide us with the following details.

Name of Doctor	First Consultation Date
Name of Clinic	
Address	

11. Has the patient ever experienced any other symptoms that may possibly be related to this condition ? ❑ Yes ❑ No
    If "Yes", plese state when (DD/MM/YYYY) _____
    Details of symptoms experienced and treatment (if any)
    _____
    _____
    _____

12. Diagnosis (including Secondary Diagnosis if any)

Diagnosed Condition	ICD Code 10	Date of first Diagnosis (DD/MM/YYYY)	Date Patient informed of Diagnosis (DD/MM/YYYY)

    Note: If there is more than one diagnosis, please advise whether they are related directly to each other.
    If "Yes", please provide us with details to your answer. ❑ Yes ❑ No

13. What was the underlying cause(s) of the diagnosed condition(s) as stated in Question 12?

14. Did patient suffer or is suffering from any other co-morbidity(ies) that is/are related to diagnosed condition(s)? ❑ Yes ❑ No

If "Yes", please specify.

Co-morbidity(ies)	Date of Treatment	Name of address of Doctor

15. Was surgery performed for the diagnosed condition(s)? ❑ Yes ❑ No

If "Yes", please specify

Date of Surgery	TOSP Code	Table	Description
If 2 or more surgeries were performed, please specify whether they were done through same incision.			
If no surgery was performed, please state treatment and/or medication given.			

16. If patient was admitted for a maternity condition, please complete this section

a. Patient's LMP (DDMMYYYY) _____

b. Is the pregnancy a result of any infertility treatment including infertility medication or conception by artificial means? ❑ Yes ❑ No

If "Yes", please provide details to your answer _____

c. Type of delivery ❑ Vaginal Delivery ❑ Elective Caesarean Section ❑ Emergency Caesarean Section

If Emergency Caesarean Section, please advise reason(s)

_____

d. Did any complications arise during pregnancy? ❑ Yes ❑ No

If "Yes", please provide details to your answer _____

17. If patient was admitted for miscarriage, please complete this section

a. Was it due to an accident ? ❑ Yes ❑ No

If "Yes", please describe how it happened? _____

If "No", please state the cause of the miscarriage?

_____

_____

18. If patient was admitted due to an accident, please complete this section

a. Was the treatment related to accident? ❑ Yes ❑ No

b. Date of accident (DD/MM/YYYY) _____

❑ Road traffic accident ❑ Work related accident ❑ Others If "Others", please specify

Please describe how it happened?

_____

_____

19. Was Patient's diagnosed condition(s) / surgery(ies) / treatment due to or related to any of the following

Is the condition / treatment related to:

(a)	Pregnancy or childbirth	❑ Yes ❑ No	(l)	Cosmetic Surgery	❑ Yes ❑ No
(b)	Abortion / Miscarriage	❑ Yes ❑ No	(m)	Mental / Psychiatric Condition	❑ Yes ❑ No
(c)	Impotency	❑ Yes ❑ No	(n)	Self-inflicted injury / Attempted Suicide	❑ Yes ❑ No
(d)	Sterilisation	❑ Yes ❑ No	(o)	Alcohol Dependence / Substance Abuse	❑ Yes ❑ No
(e)	Infertility or Sub-fertility Condition	❑ Yes ❑ No	(p)	Alcoholism	❑ Yes ❑ No
(f)	Congenital Condition	❑ Yes ❑ No	(q)	Dental Condition	❑ Yes ❑ No
(g)	Genetic	❑ Yes ❑ No	(r)	Obesity / Weight Reduction / Weight Improvement	❑ Yes ❑ No
(h)	Hereditary	❑ Yes ❑ No	(s)	Sleep apnoea / Sleep Disorder	❑ Yes ❑ No
(i)	Chromosomal Disorder	❑ Yes ❑ No	(t)	A Psychiatric Condition	❑ Yes ❑ No
(j)	Sexually Transmitted Disease	❑ Yes ❑ No	(u)	Refractive Error of the Eye(s)	❑ Yes ❑ No
(k)	AIDS / HIV	❑ Yes ❑ No	(v)	Learning Disorder / Behavioural Problem / Physical & Psychological Development Problem	❑ Yes ❑ No

20. Was the treatment a/an

❑ Experimental medical treatment ❑ Cosmetic / Plastic surgery

If you have ticked any boxes, please give details of the treatment(s) / surgery(ies).

21. If an excision was performed, please indicate the size of the lesion / tumor.

(Please attached a copy of the histology report)

22. Any other information that may assist us in the assessment of the claim.

Please also attach any other diagnostic reports (eg. Histology, Imaging, Laboratory, etc.)

23. Is the patient still under your care for this condition? ❑ Yes ❑ No

If "No", was the patient referred to another doctor for follow-up care?

Please provide the name and address of the doctor who patient has been referred to:

I hereby certify that I have personally examined and treated the patient in connection to the above condition(s) and the facts as given above represent my opnion of his / her condition. I declare and agree to make the declaration on this claim form.

Signature of Treating Doctor

Date

Name of Treating Doctor

Hospital / Clinic stamp