PMCare Pre-Admission Form

Important Note : To request a Guarantee Letter, please complete this form prior to admission and email/fax to gl@pmcare.com.my/03 8023 9999.

Hospital Name					
Contact Person		Contact No.		Fax	
Admission Date	day month year	Admission Time		am/pm	

PATIENT INFORMATION

Patient Name			
PMCare Member ID			
Company Name			
Patient IC No./Birth Certificate No.		Date of Birth	

PATIENT MEDICAL CONDITION

Presenting symptoms at time of admission and physical finding		Blood Pressure	
		Pulse	
		Respiratory rate	
		Temperature	
Is this the **FIRST TIME** patient has this/these or similar symptom(s)? If no, how long has the condition existed? When did patient first consult you for this complaint/condition?	☐ Yes ☐ No _____ year(s) _____ month(s) _____ week(s) _____day(s) _____ day _____ month _____ year		
Provisional Diagnosis			
Etiology of the above diagnosis			

Please indicate (√) if the illness/injury or treatment is/are	Motor vehicle accident related	☐ No ☐ Yes	Date of accident	day month year
	Slips, Trips or Fall	☐ No ☐ Yes	Time of accident	am/pm
	Accident at Work	☐ No ☐ Yes		
	Cosmetic/Dental Care/Refractive error			☐ No ☐ Yes
	Chronic Illnesses			☐ No ☐ Yes
	Influence of Drugs/Alcohol			☐ No ☐ Yes
	Psychological Disorder/Psychiatric/Sleeping Disorder			☐ No ☐ Yes
	Pregnancy Related /infertility			☐ No ☐ Yes
	Self-Inflicted injuries/Violation of laws/Strike/Riots			☐ No ☐ Yes
	Congenital			☐ No ☐ Yes
	STD/HIV/AIDS			☐ No ☐ Yes

Has patient suffered from/Is patient suffering any illnesses stated as follows:	Hypertension, Diabetes	☐ No ☐ Yes	Since?	day month year
	Cardiovascular Disease	☐ No ☐ Yes	Since?	day month year
	Malignancy of any kind	☐ No ☐ Yes	Since?	day month year
	Stones of the Urinary system	☐ No ☐ Yes	Since?	day month year
	ENT conditions	☐ No ☐ Yes	Since?	day month year
	Hernias, haemorrhoids	☐ No ☐ Yes	Since?	day month year
	Endometriosis	☐ No ☐ Yes	Since?	day month year
	Others	☐ No ☐ Yes	Since?	(If yes, please specify) _____ day month year

Can this condition be managed under outpatient basis?	☐ Yes ☐ No (If no, please state reason)	Reason	
Admission requires	☐ Hospitalisation ☐ Day Care ☐ On patient's request	Estimated length of stay	day
Please state **TREATMENT PLAN.** e.g. lab test, imaging, and etc	☐ Medication ☐ Procedure ☐ Surgery ☐ Physiotherapy ☐ Diagnostic Imaging ☐ Laboratory Test ☐ Others, Please specify :	**Estimated total cost** **RM**	
Signature and stamp of Admitting Physician/Surgeon			
If Admitting Doctor is a Medical Officer, please state Name and Specialty / Doctor to be referred to			