WITHOUT PREJUDICE

Certificate of Hospital Treatment

(a) Form to be filled in English only
(b) Kindly fill up the form complete in all respects and accompanied by Discharge Summary & other reports/documents
(c) Kindly be legible in filling up the form and ensure all information is declared correctly and clearly. DO NOT leave any column blank

Policy Number _____ **Patient Registration No/IP No** _____

Part I

Please provide the details of the patient as per hospital records

Name of Patient (Life Assured): _____

Date of Birth: _____

Address _____

_____

Date of Death: _____
Time of Death: _____
Was he related? (Yes/ No). If Yes, how _____

Part II

Name, Address and Telephone no. of referring doctor_____

_____

(a) What was the date of his/her admission into the hospital? _____

(b) The nature of his/her complaint? _____

(c) The duration of the complaint as reported by him/her? _____

(d) What was the exact history reported by the patient at the time of admission? _____

(e) Was the history reported by patient himself/herself? _____

(f) If not reported by the patient who reported the same? _____

(g) Who recorded the history in the case sheet? _____

(h) Tests conducted and results of the same for confirming the diagnosis_____

_____

Part III

What was the diagnosis arrived at in the hospital?_____

Treatment given _____

Duration of the treatment _____

Date of Discharge / death _____

If discharged, then condition of discharge and advice given for follow up

_____

Provide Discharge / Death Summary and Treatment Records/Papers for the above.

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Part IV

Was there any other disease or illness which preceded or co existed with the ailment at the time of his/her admission into the hospital? If so what was it? Please provide history of such disease or illness stating.

[a] Date when the patient first observed such disease _____

[b] By whom treated _____

[c] Nature of Ailment _____

[d] Hospital Name and Address _____

_____

_____

[e] Phone No. of Hospital _____

[f] Indoor Patient number _____

{g} Was the Patient suffering from any physical or Mental disability and if yes, the details thereof _____

Part V

Had the patient been admitted or treated by you or your hospital earlier Yes / No

If yes, Please provide the following details:

Date		Inpatient / Outpatient	Reason for seeking treatment	Treatment Given
From	To			

Have you attached a copy of the Indoor case papers & death / Discharge Summary YES / NO

If No, please provide reason _____

Certified that the above information is correct as per records of the Hospital.
"The information is based on records maintained in the Register No. _____Entry No._____ dated _____ "

Date: _____ Signature: _____

Name of the Doctor: _____ Qualification: _____

Registration No. _____ Designation: _____

Address of Hospital / Clinic: _____

_____

_____

Contact No: _____

Stamp of the Clinic / Hospital / Doctor

Provide Discharge / Death Summary and Treatment Records/Papers for the above.