EXPAT & CO
smart insurances

ILLNESS / ACCIDENT MEDICAL REPORT

(TO BE FILLED OUT BY THE MEDICAL SERVICE PROVIDER - PLEASE USE BLOCK CAPITALS)

Policy number .....

INFORMATION ABOUT THE INSURED PATIENT

First Name ..... Last Name .....

Address .....

.....

Postal Code ..... City ..... Country .....

Date of Birth (dd/mm/yyyy) ..... Gender M ◯ F ◯

Mobile* ..... Email .....

**please include country codes*

DOCTOR'S DETAILS AND TREATMENT INFORMATION

Docter's name .....

Address .....

Postal Code ..... City ..... Country .....

Mobile* ..... Email .....

What date was the patient first aware of symptoms/condition? (dd/mm/yyyy) .....

First symptoms .....

Diagnosis .....

Has the patient previously suffered from the same complaints?

◯ No ◯ Yes, when (last time) .....

Brief description of treatment already given .....

Reason for referral for specialist treatment .....

IN CASE OF HOSPITAL ADMISSION

Date of admission (dd/mm/yyyy) ..... Anticipated date of discharge .....

Name and address of **the hospital** .....

.....

Mobile* ..... Email .....

I declare that I am the patient's doctor and that the details given are, to the best of my knowledge, true and correct.

Date ..... Signature ..... Stamp