

บริษัท ทิพยประกันชีวิต จำกัด (มหาชน) เลขที่ 63/2 อาคาร บริษัท ทิพยประกันกัย จำกัด (มหาชน) ชั้นที่ 1,3,4,5 และ 6 ถนนพระราม 9 แขวงหัวยขวาง เขตหัวยขวาง กรุงเทพมหานคร 10310 Tel: 02 118 5555 Fax: 02 118 5601 https://www.dhipayalife.co.th

รายงานแพทย์ผู้ตรวจรักษา

| H.N | | | | | | | |
|--|--|------------------------------------|-----------------|------------------------|---|-------------------------------------|--|
| 1. CHIEF COMPLANT: 2. FOR ILLNESS A. How long had the patient experienced the symptoms? 3. FOR ACCIDENT A. Date and time of accident: Date: C. Bys/wecks/years B. How long do you feel that the symptoms existed prior to this consultation? C. Did you advise the patient to be admitted to the hospital? No Ves | | | | | | | |
| 2. FOR ILLNESS A. How long had the patient experienced the symptoms? days/weeks/years B. How long do you feel that the symptoms existed prior to this consultation? C. Did you advise the patient to be admitted to the hospital? No Yes | H.N | | | | | | |
| A. Date and time of accident: Date: | 1. CHIEF COMPLAINT: | | | | | | |
| B. How long do you feet that the symptoms existed prior to this consultations. Condition advise the patient to be admitted to the hospital? No Yes Indication for admission. Yes Yes Indication for admission. Yes Yes Indication for admission. Yes Ye | 2. FOR ILLNESS | | | | 3. FOR ACCIDENT | | |
| B. How long do you feel that the symptoms existed prior to this consultation? | A. How long had the patient experienced the symptoms? | | | | A. Date and time of accident: Date: Time: Time: | | |
| C. Was the patient under the influence of alcohol or drug at the time of antival to the hospital? No Yes Indication for admission No Yes No Yes Indication for admission No Yes No | | | | | B. Cause of accident | | |
| C. Did you advise the patient to be admitted to the hospital? No Yes Indication for admission. 4. Date first saw the patient for this illness / injury: Sa. Present illness / Details of injury: No Yes Details of injury: No Y | B. How long do you feel that the symptoms existed prior to this | | | | | | |
| Indication for admission | | | | | | | |
| 4. Date first saw the patient for this illness / injury: 5. a.) Present illness / Details of injury: b.) Pertinent clinical findings (symptoms & signs): 7. Diagnosis 1 ICD10 Diagnosis 2 ICD10 Diagnosis 3 ICD10 Diagnosis 4 ICD10 Diagnosis 4 ICD10 Diagnosis 5 ICD10 Diagnosis 6 ICD10 Diagnosis 6 ICD10 Diagnosis 7 ICD10 Diagnosis 8 ICD10 Diagnosis 9 ICD10 I | | | | | | | |
| 5. a) Present illness / Details of injury: b) Pertinent clinical findings (symptoms & signs): c) Pertinent clinical findings (symptoms & signs): c) Diagnosis 1 Diagnosis 2 (Including principle underlying condition and complication) 8. a.) Treatment (Including number of stitches, medication given, physiotherapy, etc.): b) Operation CD 9 Pathology report Surgeon's Name: c) Diagnosis and treatment by others doctors in the same occasion No Yes, please give detail. 11. Was the patient referred to you by others physician(s)? Yes No Doctor: 12. Was the injury/illness contributed to or influenced by any of the following (Pre-existing weakness or extended period of disability) a) Physical defects / congenital anomaly No Yes Yes Surgeoris name of the increased risk? e) Doctor's advice to have periodic "Medical Screening" for this disease because of increased risk? No Yes 10. A family history that increased the probability or severity of this disease Duagnosis Treatment Duration Doctor / Hospital's / Name 14. FOR FEMALE: Was the patient pregnant at the time of treatment No Yes Wiks (IMP Miles Mil | Indication for admission | | | | | | |
| b.) Pertinent clinical findings (symptoms & signs): | 4. Date first saw the patient for this illness / injury: | | | | | | |
| 7. Diagnosis 1 | 5. a.) Present ill | ness / Details of injury: | | | 6. a.) Pertinent lab / Investigations: | | |
| Diagnosis 3 | | | | | b.) HIV Test 🔲 Yes, result | No 🗖 | |
| (Including principle underlying condition and complication) 8. a.) Treatment (Including number of stitches, medication given, physiotherapy, etc.) : | | | | | | | |
| 8. a.) Treatment (Including number of stitches, medication given, physiotherapy, etc.) : | Diagnosis 3 | | ICD10 | | Diagnosis 4 | ICD10 | |
| etc.): | (Including prin | ciple underlying condition and | complication) | | | | |
| b.) Operation | 8. a.) Treatment | t (Including number of stitches, | medication give | n, physiotherapy, | 9. a.) Result of Treatment: Good | d 🔲 Fair 🔲 Poor | |
| Pathology report | etc.) : | | | | b.) Possibility of recurrence? | Yes No | |
| Specialty Date performed | b.) Operation | ICD 9 | | | | | |
| c) Diagnosis and treatment by others doctors in the same occasion No Yes, please give detail Shape Sh | Pathology repo | rt Surge | on's Name: | | 10. a.) Date of the last treatment / Follow up: | | |
| No Yes, please give detail 11. Was the patient referred to you by others physician(s)? Yes No Doctor: Clinic / Hospital: 12. Was the injury/illness contributed to or influenced by any of the following (Pre-existing weakness or extended period of disability) a.) Physical defects / congenital anomaly No Yes b.) Unfavorable past medical history No Yes Yes Ves No Yes No Yes Yes No Yes Yes If the answer is "yes", please specify No Yes Ye | Specialty | Da | te performed | | | | |
| No Yes, please give detail 11. Was the patient referred to you by others physician(s)? Yes No Doctor: Clinic / Hospital: 12. Was the injury/illness contributed to or influenced by any of the following (Pre-existing weakness or extended period of disability) a.) Physical defects / congenital anomaly No Yes b.) Unfavorable past medical history No Yes Yes Ves No Yes No Yes Yes No Yes Yes If the answer is "yes", please specify No Yes Ye | | | | | b) The patient's symptoms at the time o | f last consultations / examination? | |
| 11. Was the patient referred to you by others physician(s)? Yes No Doctor: | □ No □ Yes | , please give detail | | | | | |
| a.) Physical defects / congenital anomaly | | | | | I Clinic / Hospita | | |
| c.) Degenerative change(s) | 12. Was the inju | ury/illness contributed to or infl | uenced by any o | of the following (Pre- | existing weakness or extended period of di | sability) | |
| If the answer is "yes", please specify | a.) Physical defe | ects / congenital anomaly | □ No | ☐ Yes | b.) Unfavorable past medical history | ☐ No ☐ Yes | |
| e.) Doctor's advice to have periodic "Medical Screening" for this disease because of increased risk? f.) A family history that increased the probability or severity of this disease 13. Other past medical history Date Diagnosis Treatment Duration Doctor / Hospital's / Name 14. FOR FEMALE: Was the patient pregnant at the time of treatment No Yes | c.) Degenerative | e change(s) | □ No | ☐ Yes | d.) Alcohol or drugs = mg% | □ No □ Yes | |
| f.) A family history that increased the probability or severity of this disease 13. Other past medical history Date Diagnosis Treatment Duration Doctor / Hospital's / Name 14. FOR FEMALE: Was the patient pregnant at the time of treatment No Yes Wks. (LMP) : Was the treatment relate to infertility No Yes. | | | | | If the answer is "yes", please specify | | |
| 13. Other past medical history Date Diagnosis Treatment Duration Doctor / Hospital's / Name 14. FOR FEMALE: Was the patient pregnant at the time of treatment No Yes | | | | | | | |
| Date Diagnosis Treatment Duration Doctor / Hospital's / Name 14. FOR FEMALE: Was the patient pregnant at the time of treatment No Yes | f.) A family hist | tory that increased the probabil | | ☐ No ☐ Yes | | | |
| 14. FOR FEMALE: Was the patient pregnant at the time of treatment No Yes | 13. Other past medical history | | | | | | |
| : Was the treatment relate to infertility No Yes | Date | Diagnosis | Tr | eatment | Duration | Doctor / Hospital's / Name | |
| : Was the treatment relate to infertility No Yes | | | | | | | |
| : Was the treatment relate to infertility No Yes | | | | | | | |
| : Was the treatment relate to infertility No Yes | | | | | | | |
| <u>-</u> | 14. FOR FEMALE: Was the patient pregnant at the time of treatment No Yes | | | | | | |
| | : Was the treatment relate to infertility | | | | | | |
| 15. Other comments about the injury / illness | 15. Other comn | nents about the injury / illness | | | | | |
| I, hereby certify that I have personally examined and treated the insured in connection to the above disability and that the facts are in my opinion | | | | | | | |
| as given above. Name of physician Hospital Name Specialty License No Hospital Name | | | | | | | |
| Address | | | | | | | |
| แพทย์ผู้ตรวจรักษาซึ่งออกรายงานฉบับนี้ ต้องเป็นแพทย์ปริญญาและมีใบอนุญาตประกอบโรคศิลป์ หากมีค่าธรรมเนียมผู้เอาประกันภัยเป็นผู้รับผิดชอบ | | | | | | | |
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