



บริษัท ทิพยประกันชีวิต จำกัด (มหาชน)
 เลขที่ 63/2 อาคาร บริษัท ทิพยประกันภัย จำกัด (มหาชน)
 ชั้นที่ 1,3,4,5 และ 6 ถนนพระราม 9 แขวงห้วยขวาง
 เขตห้วยขวาง กรุงเทพมหานคร 10310
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หนึ่งในพันธมิตรของธนาคารออมสิน

รายงานแพทย์ผู้ตรวจรักษา

Patient's Name..... Age: Years Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female ID				
H.N..... A.N..... Date Admitted.....Time..... Date Discharged.....Time.....				
1. CHIEF COMPLAINT:				
2. FOR ILLNESS		3. FOR ACCIDENT		
A. How long had the patient experienced the symptoms?days/weeks/years		A. Date and time of accident: Date: Time:		
B. How long do you feel that the symptoms existed prior to this consultation?.....days/weeks/years		B. Cause of accident		
C. Did you advise the patient to be admitted to the hospital? <input type="checkbox"/> No <input type="checkbox"/> Yes		C. Was the patient under the influence of alcohol or drug at the time of arrival to the hospital? No <input type="checkbox"/> Yes <input type="checkbox"/>		
Indication for admission.....				
4. Date first saw the patient for this illness / injury:				
5. a.) Present illness / Details of injury:		6. a.) Pertinent lab / Investigations:		
b.) Pertinent clinical findings (symptoms & signs):		b.) HIV Test <input type="checkbox"/> Yes, result..... No <input type="checkbox"/>		
7. Diagnosis 1 ICD10 <input type="text"/>		Diagnosis 2 ICD10 <input type="text"/>		
Diagnosis 3 ICD10 <input type="text"/>		Diagnosis 4 ICD10 <input type="text"/>		
(Including principle underlying condition and complication)				
8. a.) Treatment (Including number of stitches, medication given, physiotherapy, etc.) :		9. a.) Result of Treatment: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		
b.) Operation ICD 9 <input type="text"/>		b.) Possibility of recurrence? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Pathology report Surgeon's Name:		10. a.) Date of the last treatment / Follow up:		
Specialty Date performed		b) The patient's symptoms at the time of last consultations / examination?		
c) Diagnosis and treatment by others doctors in the same occasion <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Yes		b.) Unfavorable past medical history <input type="checkbox"/> No <input type="checkbox"/> Yes		
c.) Degenerative change(s) <input type="checkbox"/> No <input type="checkbox"/> Yes		d.) Alcohol or drugs = mg% <input type="checkbox"/> No <input type="checkbox"/> Yes		
If the answer is "yes", please specify.....				
e.) Doctor's advice to have periodic "Medical Screening" for this disease because of increased risk? <input type="checkbox"/> No <input type="checkbox"/> Yes				
f.) A family history that increased the probability or severity of this disease <input type="checkbox"/> No <input type="checkbox"/> Yes				
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 <input type="checkbox"/> No <input type="checkbox"/> Yes Wks. (LMP)				
: Was the treatment relate to infertility <input type="checkbox"/> No <input type="checkbox"/> Yes.....				
15. Other comments 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 Specialty License No Hospital Name				
Address Tel. No Signature Date				
แพทย์ผู้ตรวจรักษาซึ่งออกรายงานฉบับนี้ ต้องเป็นแพทย์ปริญญาและมีใบอนุญาตประกอบโรคศิลป์ หากมีค่าธรรมเนียมผู้เอาประกันภัยเป็นผู้รับผิดชอบ				

