

HOSPITAL ADMISSION FORM (HAF)

HMS 24/7 CALL: 021 2927 9600 / OVERSEAS - WA ONLY: 0812-1910-2040

A. PATIENT'S SECTION

PATIENT'S NAME :
(As stated in Membership card)

POLICY NUMBER :

DATE OF BIRTH :

ID/ PASSPORT NO :

DOCTOR NAME :

CLINIC / HOSPITAL NAME :

CLINIC / HOSPITAL PHONE NO. :

CLINIC / HOSPITAL EMAIL ADDRESS :

B. HOSPITAL SECTION

Hospital Name : Correspondence Email :

Admission Date : Admission Time :

C. ATTENDING PHYSICIAN SECTION (For Completion by The Patient's Attending Physician)

1. Chief complaints :

Date first appeared/Onset Date (dd-mm-yyyy):

Physical examination findings:

Vital Signs: **Temp:** _____ **HR:** _____ **RR:** _____ **BP:** _____ **Pain Scale:** _____

2. Any previous consultation/treatment/hospitalization related with current condition? Yes No

Date (dd-mm-yyyy):	Disease/Disorder (details of treatment):	Doctor/ Hospital/Clinic:

3. According to your professional opinion as the attending doctor, how long has this illness been occurring?

*4. Kindly inform on laboratory results or investigation findings to support the diagnosis (Please describe):

***(Please supply copy of all investigation result)**

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<p>5. a) Provisional diagnosis:</p> <p style="margin-left: 20px;">Etiology:</p> <p style="margin-left: 20px;">Diagnosed since:</p> <p>b) Additional diagnosis:</p> <p style="margin-left: 20px;">Etiology:</p> <p style="margin-left: 20px;">Diagnosed since:</p>	<p>*Please provide indication for hospitalization:</p> <p>*Please provide indication for surgery (if any):</p>
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6. Please provide information on why patient's condition could not be managed under **OUTPATIENT/DAY SURGERY?**

(Please explain)

7. Please confirm if the diagnosis is directly or indirectly caused by the following condition: (please circle)

	YES	NO
Congenital		
Epilepsy		
Cataract		
COPD		
Asthma		
Tuberculosis		
Tumor/Cyst/Lump/Cancer		
Knee disorder		
Hepatitis		
HIV/AIDS/STDH/ARC		
Blood disorders		
Use of contraceptive items		
Maternity and complications related		
Fertility		
Hypertension		
Diabetes Mellitus		
Growth and Developmental disorders		
Autoimmune disorders		
Diseases of the Tonsils/Nasal Cavity/Sinuses/Ears		

	YES	NO
Disorders of the Thyroid and/or Parathyroid Glands		
Inflammation of the Stomach/Duodenum		
Ulcer of the Stomach/Duodenum		
Inflammation/Stones in the Biliary System		
Inflammation/Stones in the Kidneys/Urinary Tract		
Stroke/Cerebrovascular Disorders		
Disorders of the spine		
Diseases of reproductive system		
Anal Fistula/Anal abscess/ Haemorrhoid		
Mental disorder/Anxiety/Psychosomatic		
Suicide attempt/ Self inflicted injuries		
Cosmetic and Esthetics		
Alcoholism/Drug abuse		
Myopia/Hypermopia/Presbyopia/Astigmatism		
Dental disorders and its complications		
Cardiovascular disorders		
Dyslipidemia		
Hernia		
*Others please specify:		

8. If the hospitalization related due to **ACCIDENT / INJURY / TRAUMA**, kindly state:

a) The mechanism and cause:

b) Time of Accident:

_____ (dd/mm/yyyy)

_____ AM/PM

9. Estimated length of stay: _____ days

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10. Is there any other medical conditions presents? <input type="checkbox"/> YES <input type="checkbox"/> NO			
a.)	Since:	e.)	Since:
b.)	Since:	f.)	Since:
c.)	Since:	g.)	Since:
11. Attending doctor's treatment plan: (kindly specify)		Anesthesia type : <i>(*please circle)</i> Local / Spinal / General	Surgery type: <i>(*please circle)</i> Elective / Urgent
<ul style="list-style-type: none"> • Oral: • Injection: Name of surgery/procedures (if any):		Indication to use this anesthesia:	Number of incision:
12. Planned treatment and surgical procedure to be performed for this condition:			
Description of treatment/procedure/surgery	Procedure/TOSP Code	Estimated cost (specify currency)	Treatment/procedure date (dd/mm/yyyy)
Estimated Hospital's fee:			
<ol style="list-style-type: none"> 1. Daily Visit : 2. Surgery Fees: 3. Anaesthetist's Fee: 4. Medical implant fees (if any, *specify name of implant): 5. Facilities Fees: 			
<p>I, the undersigned hereby declare that the information on this form is true and correct in every respect.</p> <p>I have supplied full information on all particular relevance to this Patient.</p>			
Date: _____		Name & Specialty of Attending Doctor	Doctor & Hospital Stamp

KINDLY RETURN TO OUR 24 HOURS HOTLINES
ma.ops@healthmetrics.com

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