

INSURANCE MEDICAL REPORT

(Information enclosed will be treated in strictest confidence)

CLIENTS DETAILS		
Patients first name:	Last Name:	
Date of birth:	Claim No:	
Name of traveller, if different from patient:	Relationship to patient:	
TYPE OF LOSS		
<i>Please advise of any consultations, signs or symptoms relating to:</i>		
Date symptoms first appeared:	Date of first medical consultation:	
Date investigations began:	Date condition diagnosed:	
Has the patient suffered from this condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you the patients usual physician: Yes <input type="checkbox"/> No <input type="checkbox"/> If no, please provide name, address & phone number of patients usual doctor	
If "yes" please list below the patient's history of this condition & any related conditions.		
Date of consultation	Symptoms exhibited	Treatment rendered

Please provide a list of patient's current prescription medications, what condition the medication is prescribed for and when the patient commenced taking it:		
Was the condition related to alcohol, misuse of drugs or self-inflicted? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If "yes" please provide details		
Was the patient hospitalised? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Admission date: _____ Discharge Date: _____		
Name of hospital _____		
(If relevant) Was the visit related to pregnancy? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If "Yes" please provide specific details.		
Date LMP: _____ Expected Delivery date: _____		
If patient is cancelling their proposed journey, is this under your medical recommendation? If "yes" please advise when this was recommended.		
Date: _____		
Plases provide details of any other doctor who has treated the patient or referred patient to you		
Name: _____		
Address _____		
phone number: _____		
PHYSICIANS SIGNATURE		
I certify that the information in this form is complete, true and accurate to the best of my knowledge and belief.		
Physicians signature _____		
Full name (please print) _____		Physicians stamp
Date: _____		
Email address: _____		
Street Address _____		
City/Town _____		
Post code _____		
Telephone () Fax ()		