บริษัท ซิกน่า ประกันภัย จำกัด (มหาชน)
ทะเบียนเลขที่ 0107540000090
ชั้น 7 และ ชั้น 10 อาคารคิวเฮ้าส์เพลินจิต เลขที่ 598 ถนนเพลินจิต แขวงลุมพินี เขตปทุมวัน กรุงเทพฯ 10330
ศูนย์บริการลูกค้า โทร.1758 / 02-763-0000 /บริการออนไลน์ซิกน่า อี-เซอร์วิส www.Cigna.co.th / Email: Cigna.customerservice@Cigna.com

รายงานแพทย์ผู้ตรวจรักษา

แพทย์ผู้รักษาซึ่งออกรายงานฉบับนี้ ต้องเป็นแพทย์ปริญญาและมีใบอนุญาตประกอบวิชาชีพ
หากมีค่าธรรมเนียมผู้เอาประกันภัยเป็นผู้รับผิดชอบ

Patient's Name……...Age: ……..…… Years Sex : [ ] male [ ] female

ID No …….. H.N. # ……..…… A.N. # …… Date OPD…. ……

Date admitted ……Time ……..…… Date discharged ……....Time……...

1. CHIEF COMPLAINT :

……..……

2. FOR ILLNESS

A. How long had the patient experienced the symptoms? ……..……days / weeks / years.

B. How long do you feel that symptoms existed prior to this consultation? ……..…….……days / weeks / years.

C. Did you advise the patient to be admitted to the hospital? [ ] No [ ] Yes

Indication for admission ……..……

3. FOR ACCIDENT

A. Date & time of accident: Date ……Time: ……..……

B. Cause of accident: ……..……

C. Was the patient under the influence of alcohol or drug at the time of arrival to the hospital? [ ] No [ ] Yes……..……..

4. Date first saw the patient for this illness /

injury: ……..……

…..…

5. (a) Present Illness / Details of Injury : ……..……

(b) Pertinent clinical findings (symptoms & signs) ……

6. (a) Pertinent lab / Investigations: ……..……

(b) HIV Test [ ] Yes, result…… [ ] No

7. Diagnosis (including principle / underlying condition / complication)

1. ……..……ICD 10 [ ][ ][ ][ ][ ] 2. ……ICD 10 [ ][ ][ ][ ][ ]

3. ……..……ICD 10 [ ][ ][ ][ ][ ] 4. ……..……ICD 10 [ ][ ][ ][ ][ ]

8. (a) Treatments (including number of stitches, medication given, physiotherapy, etc.) :

……

(b) Operation : ……..……ICD 9 [ ][ ][ ][ ][ ] Pathology report : ……..……

Surgeon's Name ……Specialty ……..Date performed : ……..……..……..

(c) Diagnosis and treatment by other doctors in the same occasion. [ ] No [ ] Yes, please give detail

……..……..……

9. (a) Result of Treatment : [ ] Good [ ] Fair [ ] Poor

(b) Possibility of recurrence? [ ] Yes [ ] No

10. (a) Date of the last treatment / Follow up : ……..……..……..……

(b) The patient's symptoms at the time of your last consultations / examination? ……..……..……..……

11. Was the patient referred to you by other physician (s)? [ ] Yes [ ] No

Doctor: ……Clinic / Hospital: ……

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12. Was the injury / illness contributed to or influenced by any of the following (e.g. Pre-existing weakness or extended period of disability)?

a) Physical defects/congenital anomaly [ ] No [ ] Yes

b) Unfavorable past medical history [ ] No [ ] Yes

c) Degenerative change(s) [ ] No [ ] Yes

d) A family history that increased the probability or severity of this disease [ ] No [ ] Yes

e) Doctor's advice to have periodic "Medical Screening" for this disease because of increased risk? [ ] No [ ] Yes

f) Alcohol or drugs [ ] 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 …….weeks (LMP: ……...)

: Was the treatment related to infertility? [ ] No [ ] 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 …….

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