MEDICAL CERTIFICATION OF TREATMENT

SPECIAL INSTRUCTION:
(GROUP SCHEME MEMBERS): Please arrange for this Medical Certification of Treatment to be completed by your treating doctor if you have attended a Private Hospital or Hospital outside Singapore.

(INDIVIDUAL SCHEME MEMBERS): Please arrange for this Medical Certification of Treatment to be completed by your medical practitioner for treatment in all hospitals.

1. Name of patient:	**NRIC:**
2. Full description of diagnosis (based on ICD, 1975 revision, WHO) a) Principal diagnosis: b) Other diagnosis:	 ICD CODE ☐☐☐☐ ICD CODE ☐☐☐☐
3. What is the cause of the illness/injury? _____	
4. Has the patient suffered or is sufering from any other medical condition(s) that is/are related to the diagnosis in Question 2? If yes, please give details & when the condition(s) manifested. _____ _____	☐ YES ☐ NO
5. Is this treatment related to: i) Sleep Apnea ii) Obesity iii) Weight Reduction/Improvement	☐ YES ☐ NO
6. Is this treatment related to a) pregnancy or childbirth? b) abortion or miscarriage? If related to miscarriage, was it due to accident?	 ☐ YES LMP: ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO
7. Will the patient be required to undergo a) Normal Delivery b) Elective Caesarean If Elective Caesarean, please state the reason. _____ _____	 ☐ YES ☐ NO ☐ YES ☐ NO
8. Is this treatment a) related to infertility/subfertility condition? b) done to correct infertility/subfertility condition?	 ☐ YES ☐ NO ☐ YES ☐ NO
9. Is this due to self-inflicted injury or sexually transmitted disease?	☐ YES ☐ NO
10. Is this condition a) a congenital anomaly? b) a mental or nervous disorder? c) a refractive error of the eye?	 ☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO

11. Is this a) a cosmetic surgery? If No, Please explain_____ b) an oral surgery? c) a dental surgery/treatment?	☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO
12. Is this a job-related injury?	☐ YES ☐ NO
13. Has the patient ever had the same or similar condition / symptoms? If yes, please indicate when and describe.	☐ YES ☐ NO
14. Doctors previously consulted by the patient for the above condition(s).	
15. Please indicate approximate date from which the patient first notice symptoms of condition.	DD | MM | YYYY
16a. What symptoms did the patient present?	
16b. How long had the patient been troubled by them?	DD | MM | YYYY
17. Date you were first consulted for this condition.	
18a. Date of diagnosis for this condition.	DD | MM | YYYY
18b. Date patient was informed of your diagnosis	DD | MM | YYYY
19. How long had has the injury / illness been existing prior consulting you?	

20. Surgical operations performed on patient

*Operation Code	Type of Operation	*Table	Date Performed
☐☐☐☐☐☐	_____	_____	DD | MM | YYYY
☐☐☐☐☐☐	_____	_____	DD | MM | YYYY
☐☐☐☐☐☐	_____	_____	DD | MM | YYYY

_____
Date

_____
Signature of Physician/Surgeon and Official Stamp.

Name of Physician/Surgeon
Address

* This applies to operations carried out in S'pore only and refers to the classification in the Medisave table of surgical operations for private hospital.