

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:	ICD CODE <input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/>
b) Other diagnosis:	ICD CODE <input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/>
3. What is the cause of the illness/injury? _____	
4. Has the patient suffered or is suffering 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. _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Is this treatment related to: i) Sleep Apnea ii) Obesity iii) Weight Reduction/Improvement	<input type="checkbox"/> YES <input type="checkbox"/> NO
6. Is this treatment related to a) pregnancy or childbirth? b) abortion or miscarriage? If related to miscarriage, was it due to accident?	<input type="checkbox"/> YES LMP: <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
7. Will the patient be required to undergo a) Normal Delivery b) Elective Caesarean If Elective Caesarean, please state the reason. _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
8. Is this treatment a) related to infertility/subfertility condition? b) done to correct infertility/subfertility condition?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
9. Is this due to self-inflicted injury or sexually transmitted disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO
10. Is this condition a) a congenital anomaly? b) a mental or nervous disorder? c) a refractive error of the eye?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO

<p>11. Is this</p> <p>a) a cosmetic surgery? If No, Please explain _____</p> <p>b) an oral surgery?</p> <p>c) a dental surgery/treatment?</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>																
<p>12. Is this a job-related injury?</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>																
<p>13. Has the patient ever had the same or similar condition / symptoms? If yes, please indicate when and describe.</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>																
<p>14. Doctors previously consulted by the patient for the above condition(s).</p>																	
<p>15. Please indicate approximate date from which the patient first notice symptoms of condition.</p>	<p><input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/></p>																
<p>16a. What symptoms did the patient present?</p>																	
<p>16b. How long had the patient been troubled by them?</p>	<p><input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/></p>																
<p>17. Date you were first consulted for this condition.</p>																	
<p>18a. Date of diagnosis for this condition.</p>	<p><input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/></p>																
<p>18b. Date patient was informed of your diagnosis</p>	<p><input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/></p>																
<p>19. How long had has the injury / illness been existing prior consulting you?</p>																	
<p>20. Surgical operations performed on patient</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;"><u>*Operation Code</u></th> <th style="width: 35%;"><u>Type of Operation</u></th> <th style="width: 15%;"><u>*Table</u></th> <th style="width: 25%;"><u>Date Performed</u></th> </tr> </thead> <tbody> <tr> <td><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/></td> <td>_____</td> <td>_____</td> <td><input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/></td> </tr> <tr> <td><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/></td> <td>_____</td> <td>_____</td> <td><input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/></td> </tr> <tr> <td><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/></td> <td>_____</td> <td>_____</td> <td><input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/></td> </tr> </tbody> </table> <p>_____ Date _____ Signature of Physician/Surgeon and Official Stamp.</p> <p>Name of Physician/Surgeon Address</p> <p><small>* 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.</small></p>		<u>*Operation Code</u>	<u>Type of Operation</u>	<u>*Table</u>	<u>Date Performed</u>	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>	_____	_____	<input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/>	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>	_____	_____	<input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/>	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>	_____	_____	<input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/>
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