Discharge Notification Form

Company name..... Hospital Name.....

Part B

Medical certification

Patient's Name: ..... Sex ○ Male ○ Female HN : ..... AN: .....Age..... Year(s) .....Month(s)

Admission Date: ..... Time: ..... Discharge Date: ..... Time: ..... Consultation Date: .....

1. For Illness

a) Date you first saw this patient for this illness: .....

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b) Chief complaint and duration of symptom(s):

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2. For Injury

a) Date of injury..... Time: .....

b) Cause of injury.....

c) Details of injury .....

d) Did you smell alcohol from the patient?

( ) No ( ) Not known

( ) Yes**,** blood alcohol test (if any) = ... mg%

e) Level of consciousness ( ) Normal ( ) Confusion

( ) Drowsiness ( ) Semi-coma ( ) Coma

f) Estimated time for recovery

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3. Did the patient need to be admitted to hospital? ( ) No ( ) Yes, indication for admission.....

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4. Vital signs: T..... P..... R ..... BP.....

5. Pertinent Clinical findings (Symptoms & Signs) .....

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6. Investigation & Result (Lab, EKG, X – ray, etc.) .....

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7. HIV Test ( ) No ( ) Yes, Result : ..... Date performed: .....

8. Underlying disease: .....

9. Diagnosis 1: .....ICD10-TM: .....

Diagnosis 2: .....ICD10-TM: .....

Diagnosis 3: .....ICD10-TM: .....

Adjusted RW	

10. Treatment: .....

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11. Surgery/Operation: ..... ICD9-CM: ..... Date performed: .....

Anaesthesia Type: ( ) General Anaesthesia ( ) Spinal Anaesthesia ( ) Local Anaesthesia ( ) Others .....

12. Pathological report: .....

13. Complications (if any): .....

14. Is the illness related to alcohol, drug abuse or addiction? ( ) No ( ) Yes, please specify .....

15. For Female: Is the patient pregnant? ( ) No ( ) Yes, gestational age ..... weeks

Was the treatment related to infertility? ( ) No ( ) Yes, please specify .....

16. Has patient ever been treated by another doctor before? ( ) No ( ) Yes, please give name and address .....

17. Was the illness/injury contributed to or influenced by any of the following

a) Physical defects/congenital anomaly ( ) No ( ) Yes

b) Degenerative change(s) ( ) No ( ) Yes

18. Others past medical history

Date	Signs & Symptoms	Diagnosis	Treatment	Hospital

19. Other comments about the injury / illness.....

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I, hereby certify that I have personally examined and treated the insured in connection with the disability and that the facts are in my opinion as given above.

Physician's Signature ..... Medical Specialty: ..... Thai Medical license No: .....

(.....) Tel.: ..... Date: .....

Medical Institute: ..... Address: .....

Remark: A physician who issues this report must be licensed to practice medicine and duly registered by the Thai Medical Council.