

ILLNESS / ACCIDENT MEDICAL REPORT

(TO BE FILLED OUT BY THE MEDICAL SERVICE PROVIDER - PLEASE USE BLOCK CAPITALS)

Policy number

INFORMATION ABOUT THE INSURED PATIENT

First Name Last Name

Address

Postal Code City Country

Date of Birth (dd/mm/yyyy) Gender M F

Mobile* Email

**please include country codes*

DOCTOR'S DETAILS AND TREATMENT INFORMATION

Doctor's name

Address

Postal Code City Country

Mobile* Email

What date was the patient first aware of symptoms/condition? (dd/mm/yyyy)

First symptoms

Diagnosis

Has the patient previously suffered from the same complaints?

No Yes, when (last time)

Brief description of treatment already given

Reason for referral for specialist treatment

IN CASE OF HOSPITAL ADMISSION

Date of admission (dd/mm/yyyy) Anticipated date of discharge

Name and address of **the hospital**

Mobile* Email

I declare that I am the patient's doctor and that the details given are, to the best of my knowledge, true and correct.

Date Signature Stamp

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