SECTION II – To be completed by the Attending Doctor (IN BLOCK LETTERS) **MRN No:**
(Certificate of Hospitalisation)

Name of Hospital and Address

Name of Patient | NRIC No.

Date and Time of Admission
☐ (dd) ☐ (mm) ☐ (yy) ☐ (hrs)

Date and Time of Discharge
☐ (dd) ☐ (mm) ☐ (yy) ☐ (hrs)

Name of Referring Doctor and Address

Date of Referral (dd mm yy):

Admitting Doctor | Attending Doctors | Speciality

1a. Diagnosis

1b. Cause and Pathology of the above diagnosis

1c. Date first diagnosed:
☐ (dd) ☐ (mm) ☐ (yy)

1d. Since when has the patient undergone consultation/ treatment/medication for these symptoms ?
☐ (dd) ☐ (mm) ☐ (yy)

2a. When did patient first consult you for this condition?
☐ (dd) ☐ (mm) ☐ (yy)

2b. Was the patient previously treated for this condition? € No € Yes, give details and when
☐ (dd) ☐ (mm) ☐ (yy)
.....
.....
.....

2c. How long in your professional opinion has the condition existed?
☐ (dd) ☐ (mm) ☐ (yy)

4a. Please✓ Nature of Treatment and Investigation:

€ OPERATION: .....
€ PHYSIOTHERAPY € DIETARY COUNSELLING
€ X-RAY € MEDICATIONS
€ BLOOD TESTS
€ OTHERS, give details .....
.....
.....

Anaesthesiologist: .....

4b. If more than one procedure was involved, please state Type of Procedures performed:

	TYPE	DATE	NAME OF DOCTOR
i.			
ii.			
Iii.			

4c. Other medical conditions present?
.....
Since (dd mm yy) .....
.....
Since (dd mm yy) .....
.....
Since (dd mm yy) .....

3. Any possibility of a relapse?
€ Yes € No

5. Was the condition
☐ congenital ☐ nervous ☐ mental

6. Was the patient pregnant at the time of hospitalisation? (For Females Only)
€ No € Yes, ...months

7. If the hospitalisation was due to accident, please indicate date/time of accident:
☐ (dd) ☐ (mm) ☐ (yy) ☐ (hrs)

8. Discharge/Follow-up instructions

....
Signature and Name of Attending Doctor | Hospital Stamp | Date