# Prime Islami Life Insurance Limited

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## Hospitalization Scheme for Employees
## Physician's Declaration Form

This form should be filled in by the doctor who treated the patient while confined at a hospital/ clinic. Code No. is to be quoted if the doctor is registered with Prime Islami Life Insurance Limited . for others, a witness from a respectable person is required.

1. Name of the Patient:..... 2. Age:.....
3. Name of Hospital/ Clinic with Address:.....
4. Ward/ Cabin no..... 5.Date & time of admission.....
6. Date & time if discharge.....
7. Was the patient admitted on emergency basis: Yes ☐ No ☐
8. What was the primary cause of admission:.....
9. Was there any associated cause ( Specify):.....
10. Date on which you examined the patient first:.....
11. Where did you examine him first? Hospital / Clinic ☐ Residence ☐ Chamber ☐
12. What were the main complains of the patient:

| Complains | Duration |
|---|---|
| i) ..... | |
| ii) ..... | |
| iii) ..... | |

13. Did you treat the patient from start of his ailments: Yes ☐ No. ☐
    Please quote exact duration of your treatment: From .....to .....
14. Please enumerate the investigations done for this Patient while confined.
    a) Blood:.....b) Urine.....
    c) Stool.....d) X-ray.....e) Others.....
15. Did you ask for any investigation to be done from outside: Yes ☐ No ☐
16. Did you ask for any Medicine to be bought from outside: Yes ☐ No ☐
17. Did any other doctor treat the patient (While confined) Yes ☐ No ☐
    (If yes) Did he treat the patient in consultation with you? Yes ☐ No ☐
18. In your opinion, since how long the patient is suffering from this disease?.....
19. Did the patient suffer or was suffering from any other disease immediately before or during confinement? Yes ☐ No ☐
    (If Yes) Name of disease and since how long the disease was present?.....
20. Did you treat the same patient at any time before ? Yes ☐ No ☐
    (If Yes) When & Why ? .....

21.Are you the family physician of this patient? Yes No

22. Did the patient undergo surgical treatment ? Yes ☐ No ☐

( If yes ) Date of operation .....Nature of operation.....

23. What was the condition of the patient during release from hospital ?

24. Mode of Discharge: Normal ☐ D.O.R ☐ D.O.R.B ☐

Refd for better treatment

25. Did the patient refuse treatment you suggested ? Yes ☐ No ☐

I Dr. .....do solemnly declare that the statement given by me is true and complete to my knowledge. I also agree to co-operate with PILIL for investigation regarding treatment of this patient & I have no objection in providing any information if required for the same.

.....
Signature of the attending Physician

.....
(Official Seal)

Full Name:.....

Degree:.....

Registration No:.....

Code No. PILIL (if any):.....

Address:.....

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Signature of witness

**Witness**

Full Name:.....

Designation:.....

Address:.....

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