THC000101

Canara HSBC LIFE INSURANCE

Hospital Treatment Form: (Form–H)

Important Information:
1. This form is to be completed by the authorities at all the hospitals where the patient (Life Assured) was hospitalized
2. Please attach the patient admission sheet, investigations, history sheet, treatment records along with this form
3. One form is to be filled up per hospital/ nursing home

Please provide the following information based on the medical records and annex supporting documents

Policy no(s) _____

i. Name of the Patient/ Life Assured _____

ii. Age_____ years, Any mark of identification? _____

iii. Date and Time of admission / / ; : (a.m. / p.m.) Admission no. _____

ii. Was the patient (Life Assured) referred by any doctor/ hospital Yes No

If yes, then provide with the name and address _____

_____ Contact no. _____

iii. What were the complaints/ condition of the patient (Life Assured) at the time of admission

_____

_____

iv. What was the exact nature and duration of the illness suffered by the patient (Life Assured)? (Please enclose admission notes)

_____

v. Was the history of illness reported by the patient himself? Yes No

If no, then by whom the history was reported _____

vi. Name of the doctor who recorded the history with qualification _____

vii. Did the patient (Life Assured) suffer from any past ailment as disclosed at the time of admission? Yes No

If yes, then provide details of the nature of the ailment and its duration: _____

_____

(*Annex supporting documents)

viii. What was the diagnosis made at the hospital _____

_____

ix. What were the tests/ investigations undergone by the patient (Life Assured) at the hospital to confirm the diagnosis? (Please attach separate sheets if required) _____

_____

_____

_____

x. When was the diagnosis confirmed at the hospital?

_____

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xi. What was the treatment given to the patient (Life Assured) during the hospitalization?

_____

_____

xii. Was/ were there any other contributory illnesses/ chronic ailments suffered by the patient (Life Assured) that existed at the time of admission? Yes No

If yes, detail _____

_____

_____

xiii. What was the date of discharge from the hospital? / /

xiv. What was the condition of the patient (Life Assured) at the time discharge?

_____

_____

xv. Was the patient (Life Assured) treated at the hospital at any other occasion as an out-patient or inpatient? Yes No

If yes, please provide details _____

_____

xvi. Was the patient (Life Assured) treated by any other medical practitioner/hospital during the past 3 years? Yes No

If yes then provide the details:

Name	Address	Contact No.

Certified that the above information is correct as per hospital records:

Date: / / Place _____ Signature: _____

Name and Designation of the Doctor:_____

Qualifications and Registration number of the Doctor:_____

Name of the Hospital:_____

Registration Number of the Hospital:_____

Address:_____

Telephone Number _____

Seal / Stamp of the Hospital:

(Mandatory)