Great Eastern General Insurance (Malaysia) Berhad (102249-P)
(Formerly known as Overseas Assurance Corporation (Malaysia) Berhad)
Level 18, Menara Great Eastern, 303, Jalan Ampang, 50450 Kuala Lumpur
General Line: +603 4259 8888 Fax: +603 4813 0055
Customer Service Careline: 1300-1300 88
Website: www.greateasterngeneral.com

Great Eastern
A member of the OCBC Group

Policy No: _____ **Claim No :** _____

Note: To be completed by attending doctor at patient's own expense. If space provided is insufficient, please attached separate sheet.

MEDICAL REPORT

Name:		I/C No:
Patient Ref No:	Age:	Occupation:
Date of Accident:	Time of Accident:	Date first consulted:

1. Name of Referral Doctor: Date of Referral:	Address of Referral Doctor:
2.(a)) Describe in detail the nature of accident as related to you by the patient.	2.(b) Describe in detail nature of illness/ injury. Is condition due to pregnancy? Yes / No
3.(a) Were there any external and visible injuries seen as a result of this accident? (b) If yes, describe the extent of injuries including site and other characteristic features as seen by you.	3.(a) Yes / No (b)
4 Are the patient's symptoms: (a) Due sole to this accident or (b) If yes, describe the extent of injuries including site and other characteristic features as seen by you.	4.(a) (b)
5 Is the patient now or was he at the time of the accident suffering from any illness, disease or infirmity? If so, state the nature and to what extent his recovery has been or may be retarded thereby.	

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6 Treatments given including follow-up (such as number of stitches, physiotherapy, type of dressing, etc.)

Date(s)	Time (am/ pm)	Treatments

7 Name and address of other physician who treated patient for the same injury:

Name	Address	Approximate date(s)

8 Did the injuries require any of the following:

(a) Hospitalisation Yes / No Date admitted: _____ Date discharged: _____

(b) Surgery Yes / No Type of surgery performed: _____

_____

(c) X-ray Yes / No Please enclose a copy of the x-ray report.

(d) Special diagnostic procedure or treatment Yes / No Type of procedure/ treatment: _____

_____

(e) Was there any limitation of movement on any joint at the last day of treatment. If yes, please give details. Yes / No

Details of limitation: _____

_____

9 Is the patient suffering from any permanent total/ permanent partial disablement (loss of use/ function) due to this incident?

No / Yes , 100% Permanent Total Disablement

Yes, Permanent Partial Disablement at _____ %

Date of final assessment: _____

If yes, please also provide the date of the onset of the permanent disablement: _____

Detailed description of the permanent disablement: _____

_____

10 Have you any reason to suppose that the patient was under the influence of intoxicants at the time of the accident?

(a) If yes, please advise if blood and/ or urine sample was taken.

(b) Please provide the readings.

Declaration

I hereby certify that I have personally examined and treated the patient for his/ her injuries described above and that the facts as stated above represent my medical opinion of his/ her condition.

_____ _____

Hospital/ Clinic Stamp

Signature of doctor

Name of doctor: _____

Qualification : _____

Tel No. : _____ Date:_____