ทิพยประกันชีวิต
DHIPAYA LIFE ASSURANCE
หนึ่งในพันธมิตรของธนาคารออมสิน

บริษัท ทิพยประกันชีวิต จำกัด (มหาชน)
เลขที่ 63/2 อาคาร บริษัท ทิพยประกันภัย จำกัด (มหาชน)
ชั้นที่ 1,3,4,5 และ 6 ถนนพระราม 9 แขวงห้วยขวาง
เขตห้วยขวาง กรุงเทพมหานคร 10310
Tel: 02 118 5555 Fax: 02 118 5601
https://www.dhipayalife.co.th

รายงานแพทย์ผู้ตรวจรักษา

Patient's Name..... Age: ..... Years Sex: ☐ Male ☐ Female ID .....

H.N..... A.N..... Date Admitted.....Time..... Date Discharged.....Time.....

1. CHIEF COMPLAINT: .....

2. FOR ILLNESS

A. How long had the patient experienced the symptoms?

.....days/weeks/years

B. How long do you feel that the symptoms existed prior to this consultation?.....days/weeks/years

C. Did you advise the patent to be admitted to the hospital? ☐ No ☐ Yes

Indication for admission.....

3. FOR ACCIDENT

A. Date and time of accident: Date: ..... Time: .....

B. Cause of accident

.....

C. Was the patient under the influence of alcohol or drug at the time of arrival to the hospital? No ☐ Yes ☐

.....

4. Date first saw the patient for this illness / injury: .....

5. a.) Present illness / Details of injury: .....

b.) Pertinent clinical findings (symptoms & signs): .....

6. a.) Pertinent lab / Investigations: .....

b.) HIV Test ☐ Yes, result..... No ☐

7. Diagnosis 1 ..... ICD10 ☐☐☐☐ Diagnosis 2 ..... ICD10 ☐☐☐☐

Diagnosis 3 ..... ICD10 ☐☐☐☐ Diagnosis 4 .....ICD10 ☐☐☐☐

(Including principle underlying condition and complication)

8. a.) Treatment (Including number of stitches, medication given, physiotherapy, etc.) : .....

b.) Operation ..... ICD 9 ☐☐☐☐

Pathology report ..... Surgeon's Name: .....

Specialty ..... Date performed .....

c) Diagnosis and treatment by others doctors in the same occasion

☐ No ☐ Yes, please give detail .....

9. a.) Result of Treatment: ☐ Good ☐ Fair ☐ Poor

b.) Possibility of recurrence? ☐ Yes ☐ No

10. a.) Date of the last treatment / Follow up:

.....

b) The patient's symptoms at the time of last consultations / examination?

.....

11. Was the patient referred to you by others physician(s)? Yes No Doctor: .....Clinic / Hospital: .....

12. Was the injury/illness contributed to or influenced by any of the following (Pre-existing weakness or extended period of disability)

a.) Physical defects / congenital anomaly ☐ No ☐ Yes

b.) Unfavorable past medical history ☐ No ☐ Yes

c.) Degenerative change(s) ☐ No ☐ Yes

d.) Alcohol or drugs = ... mg% ☐ No ☐ Yes

If the answer is "yes", please specify.....

e.) Doctor's advice to have periodic "Medical Screening" for this disease because of increased risk? ☐ No ☐ Yes

f.) A family history that increased the probability or severity of this disease ☐ No ☐ Yes

13. Other past medical history

Date	Diagnosis	Treatment	Duration	Doctor / Hospital's / Name

14. FOR FEMALE: Was the patient pregnant at the time of treatment ☐ No ☐ Yes ..... Wks. (LMP .....)

: Was the treatment relate to infertility ☐ No ☐ Yes.....

15. Other comments about the injury / illness .....

I, hereby certify that I have personally examined and treated the insured in connection to the above disability and that the facts are in my opinion as given above. Name of physician ..... Specialty ..... License No ..... Hospital Name .....

Address ..... Tel. No ..... Signature ..... Date .....

ประทับตรา
โรงพยาบาล

แพทย์ผู้ตรวจรักษาซึ่งออกรายงานฉบับนี้ ต้องเป็นแพทย์ปริญญาและมีใบอนุญาตประกอบโรคศิลป์ หากมีค่าธรรมเนียมผู้เอาประกันภัยเป็นผู้รับผิดชอบ