# MCOCARE MEDICAL FORM

**MCOCARE SDN BHD (1028557-W)**
No. 21-1 & 21-2, Selayang Point, Jalan SP1, 68100 Batu Caves, Selangor.
Careline: 03 - 6126 7999 Fax: 03-2050 2776

Hospital

Contact & Fax No | Admission Date & Time

## PATIENT PARTICULAR

Name :

MCOCARE ID : | Gender :

Employer : | Birth Date :

NRIC / Birth Certificate : | Tel. No :

## AUTHORIZATION

***I hereby authorize any surgeons, medical practitioners, hospitals or clinics or other persons who have attended or examined me or my dependent for any reasons to disclose any and all information with respect to any illnesses or injuries and to provide copies of all medical reports, including earlier medical history to MCOCARE Sdn Bhd, insurer and/or my Employer for claims processing, payment, and to produce report. I hereby undertake to reimburse MCOCARE Sdn Bhd in the event that the hospitalization costs are not covered by the policy.***

Signature & Name of patient / claimant | Date :

## ADMISSION / OUTPATIENT / DAYCARE

Attending Doctor & Specialty :

1. Is the admission due to accident ? Yes / No

   Nature of accident : | Date / Time :

2. Is the visit categorized as emergency medical illness ? Yes / No

   Presenting symptom : | Since / Duration :

3. Provisional diagnosis :

4. Is the patient referred to you ? Yes / No ***if yes, please attached the referral letter with the medical form***

5. Is there any condition / illness that caused or is related to the present illness ? Yes / No

   If yes, please specify | Since :

6. Has the patient ever had any of the following illness / condition ?

| | | | |
|---|---|---|---|
| Hypertension | ☐ Yes ☐ No | Since : | |
| Hyperlipidemia | ☐ Yes ☐ No | Since : | |
| Diabetes Mellitus | ☐ Yes ☐ No | Since : | |
| Stroke / TIA / Epilepsy | ☐ Yes ☐ No | Since : | |
| SLE / Rheumatoid / Connective Tissue Disease | ☐ Yes ☐ No | Since : | |
| STD / HIV / AIDS | ☐ Yes ☐ No | Since : | |
| Heart Disease / Vascular Disease | ☐ Yes ☐ No | Since : | |
| *Please specify :* | | | |
| Cancer / Tumour | ☐ Yes ☐ No | Since : | |
| *Please specify :* | | | |

7. Is the present illness / injury or treatment :

| | |
|---|---|
| Congenital | ☐ Yes ☐ No |
| Hereditary | ☐ Yes ☐ No |
| Psychological Disorder / Psychiatric | ☐ Yes ☐ No |
| Pregnancy related | ☐ Yes ☐ No |
| Infertility | ☐ Yes ☐ No |
| Cosmetic / Dental Care / Refractive error | ☐ Yes ☐ No |
| Influence of Drugs / Alcohol | ☐ Yes ☐ No |
| Self-Inflicted injuries / Violation of laws / Strike / Riots | ☐ Yes ☐ No |

**Estimated Total Cost (RM)**

8. Investigation required :

9. Procedure / Treatment required :

**I hereby certify that all the information given above are true and accurate.**

Signature & Stamp of Attending Doctor | Hospital Stamp | Date / Time

## DISCHARGE

1. Final diagnosis :
2. Summary of medications :
3. Result of investigation :
4. Surgery / Procedure :

**I hereby certify that all the information given above are true and accurate.**

Signature & Stamp of Attending Doctor | Hospital Stamp | Date / Time