MATERNITY

MEDICAL STATEMENT

(Please use block letters)

THE PATIENT

First name(s)

Family name(s)

Date of birth d d m m y y y y   Policy Number —

Address

Postal Code   City

Country

NAME AND CONTACT DETAILS OF THE TREATING GYNAECOLOGIST/OBSTETRICIAN

Name

Telephone

Fax

Email

NAME AND CONTACT DETAILS OF THE HOSPITAL/CLINIC WHERE THE BIRTH TAKES PLACE

Name

Telephone

Fax

Email

TO BE COMPLETED BY THE TREATING PHYSICIAN

1) Current pregnancy

Date of first day of last menstruation d d m m y y y y

Expected date of delivery d d m m y y y y

☐ Normal delivery **or** ☐ Planned C-section

If planned C-section, please state the indication:

Expected length of stay in hospital (number of days)

Has the patient received any fertility/hormone treatment or any hormone injections in connection with this pregnancy?

☐ Yes ☐ No

If yes, please state place and type of treatment:

Other comments:

ihi Bupa ∘ Customer Service ∘ Palægade 8 ∘ DK-1261 Copenhagen K ∘ Denmark ∘ Tel: +45 70 23 00 42 ∘ Fax: +45 33 32 25 60 ∘ Email: ihi@ihi.com ∘ www.ihi.com
Medical Centre ∘ Tel: +45 70 23 24 60 ∘ Tel: Email: emergency@ihi.com

ihi Bupa is a trading name of Bupa Insurance Limited. Registered in England No. 3956433. Registered office: Bupa House, 15-19 Bloomsbury Way, London WC1A 2BA, UK

TO BE COMPLETED BY THE TREATING PHYSICIAN

1) Current pregnancy — continued

Has the patient required any form of assistance to conceive, including:

Medical treatment	☐ Yes	☐ No
Surgical intervention	☐ Yes	☐ No
Assisted conception	☐ Yes	☐ No

If yes, what were the underlying cause, diagnosis and treatment?

2) Medical history of previous pregnancies

Number of earlier pregnancies ☐☐☐☐ Number of births ☐☐☐☐

History of pregnancy:

Number of miscarriages ☐☐☐☐

History of miscarriages:

Did the patient have any complications in connection with earlier pregnancies? ☐ Yes ☐ No

If yes, please specify:

Has the patient ever received fertility/hormone treatment or any hormone injections? ☐ Yes ☐ No

If yes, please state place and type of treatment:

Are there any relevant factors, diseases, symptoms or complications other than those specified above? ☐ Yes ☐ No

If yes, please specify:

Other comments:

TO BE COMPLETED BY THE ADMINISTRATION

Currency ☐☐☐ Estimated costs for the hospital charges ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Currency ☐☐☐ Estimated costs for the physician's charges ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Other comments:

SIGNATURE

Date d d m m y y y y

Doctor's stamp

Doctor's signature

222321 v3_Medical Statement_Maternity_ENG