# HOSPITAL FORM For ADMISSION

AA INTERNATIONAL

**Policy No.:** _____

**Patient name** (as stated in Membership Card)**:**

_____

**NRIC/Passport/Birth Cert. No.:** _____ **AGE:** _____

**--- 24 HOURS HOTLINES ---**

Tel : 6827 7688
Fax: 6235 0739

**Hospital section below:**

| | |
|---|---|
| Hospital:<br>Contact Person: | **Tel:**<br>Fax: |
| **ADMISSION DATE** (dd/mm/yyyy): | **TIME** (HH:MM): am/pm |

**Doctor's section below:**

1) Presenting **SYMPTOMS** at time of Admission:

Date first appeared: did / mm / yyyy

2) Physical Findings:

3) Vital Signs:
Temp.:
Pulse:
Resp.:
BP:

4) Any previous consultation / treatment / hospitalization for this condition, in this hospital or any other facilities?
*If YES, please provide details below;*

| Date | Disease / Disorder *(details of treatment)* | Doctor / Hospital | Contact details |
|---|---|---|---|

5a) Provisional **DIAGNOSIS**:

Date first appeared: dd / mm / yyyy

5b) **ETIOLOGY** of the above diagnosis:

5c) Can the condition be managed under **OUTPATIENT** basis ?
☐ Yes ☐ No *If No, please provide details:*

5d) Was the patient pregnant at time of hospitalization ?
(For Female Only)
☐ No ☐ Yes _____Weeks

6) If the hospitalization was due to **ACCIDENT**, please indicate: _____ dd / mm / yyyy _____ am / pm
*Please describe the mechanism and cause of injury:*

7) Treatment, Investigation and Surgical procedure to be performed, if any: *(Please supply copy of all investigation results)*

8) Was the diagnosis arising from or related to: *(please circle whichever applicable)*

a) Yes / No Pregnancy / Childbirth / Infertility
b) Yes / No Congenital / Hereditary disease
c) Yes / No Influence of Drugs / Alcohol
d) Yes / No Injury/Illness sustained while serving as a full-time member of a police or military unit including reservist
e) Yes / No HIV / AIDS / STD
f) Yes / No Nervous / Mental / Anxiety
g) Yes / No Attempted Suicide / Self-Inflicted

9) Is there any other medical conditions present ? ☐ No ☐ Yes, details below:
i) since dd / mm / yyyy
ii) since dd / mm / yyyy

Estimated fees for surgeon and anaesthetist:

*1) Daily visit fees* *SGD$:*
*2) Surgery fees* *SGD$:*
*3) Treating doctor's total estimate (1+2)* *SGD$:*
*4) Anaesthetist's fees* *SGD$:*

**Estimated length of stay :** _____

Estimated hospital's fees:

*Please indicate the type of room patient admitted into :*
*Single standard / Double / Others:* _____
*Room rate per night:* *SGD$:*
*Total room & hospital's fees (excluding doctor's fees):* *SGD$:*

*I, the undersigned hereby declare that the information on this form is true in every respect. I have supplied full information on all particular relevant to this patient.*

| Date | Name & Specialty of Attending Doctor | Doctor / Hospital stamp |
|---|---|---|