PRE - ADMISSION FORM

Private and Confidential

International Assistance Sdn. Bhd.
Healthcare Assistance and Contact Centre Outsourcing

IA International Assistance Sdn Bhd
Unit I-5, Sunway PJ51A Jalan SS9A/19
KG Baru Sungai Way 47300
Petaling Jaya, Selangor Darul Ehsan
Tel: 1800-22-0911 Fax: 603-7875 1911

Part 1. (To be completed by Patient / Claimant)

1. Patient Name :	2. NRIC / Passport No. :
3.a.Date of Birth : b. Age :	c. Sex : ☐ Male ☐ Female
4. Policy No/Member ID/ Certificate No/Plan/ Company Name :	5. Admission/ Planned Admission Date :
6. Hospital Name :	7. Name of attending Doctor / Speciality :

Admission Reason (✔) and answer accordingly

☐ 8. Accident	a. Occurred on : Date ______ / ______ / ______ Time _________ ☐ am ☐ pm b.Details of Accident :
☐ 9. Illness	a. Symptoms first appeared on : Date _______ / ________ / ________ b. Doctor(s) consulted for this condition : c. Doctor's or Clinic Contact (Address & Telephone) :

Goods & Services Tax (GST) Information

10. Are you GST registered? ☐ Yes ☐ No If "Yes", please provide your GST Registration Number:

The Company shall rely on the above information provided by your tax credit purpose provided under the GST Act. The Company shall not be liable for any fine, charge or penalty as a result of relying on your incorrect advice. Should action be taken against the Company and / or penalties be imposed on the Company by any tax authority for relying n the same, the Company reserves its right to be indemnified by you to the fullest extent permitted by law and any GST liability arising from your incorrect advice shall be payable by you.

11. Declaration and Authorization

I declare that the answers given above are true and complete to the best of my knowledge and belief
I understand the delivery of this form is in no way an admission of Company's liability and payment to the hospital by the Company or its representative shall not be construed as final admission of the Company's liability and for this and any further claims arising. The Company reserves all rights for evaluation as appropriate.

I am fully aware of the limits as to my /Assured medical insurance under the above mentioned policy. I hereby undertake to settle/reimburse any medical expenses exceeding my entitlement under the said policy contract or that is not covered by the same.

I hereby irrevocable authorize any organization, institution, or individual that has any record or knowledge of my health and medical history or treatment or advice that has been or may hereafter be consulted, other personal information or details of accident/injury, to disclose to the Company or its representative such information. I agree that the Company or its representative may use or disclose any of the information collected or held to third parties (within or outside Malaysia, including the Company's parent company, subsidiaries or any other associated companies within the Company's Group, re insurers, medical examiners, claims investigators and industry associations/federations etc, in relation to this claim. This authorization shall bind my / the Assured's / Insured's successors and assigns and remain valid notwithstanding my /Assured's/Insured's Incapacity in so far as legally possible. A photocopy of this authorization shall be valid as the original. I agree that in the event I make, or have in the past made, any false or untrue statement and/or concealed any material facts in respect of my/the Insured condition, the Company shall absolutely forfeit my/the Insured's/ Assured's right to compensation and further reserves the right to recover any amounts paid earlier a result thereof.

Signature of Patient	Signature of Assured/claimant	Signature of Witness
____________________________	____________________________	____________________________
Full Name :	Full Name :	Full Name :
IC / Passport No. :	IC / Passport No. :	IC / Passport No. :
Date :	Date :	Date :
Contact No :	Contact No :	Contact No. :
	Relationship to Patient :	:

NOTE : COMPLETION OF THIS PRE ADMISSION FORM DOES NOT GUARANTEE THE ISSUANCE OF GUARANTEE LETTER

Part 2. ADMISSION SECTION (*To be completed upon admission by Doctor*)

1.a. Patient Name :

b. NRIC / Passport No. :

c. Age :

d. Sex ☐ Male ☐ Female

2.Policy No./ Member ID / Certificate No / Plan / Company No :

3. Admission No. MRN and Hospital Name / Hospital Contact and Fax No.

4. Admission Date and Time :
(dd/mm/yy) Date ___ /____ /____ Time _____ ☐ am ☐ pm

5. Expected days of stay / Discharge Date :

6.a. Symptoms / conditions requiring admission :

b. How long is patient aware of the condition :

c. Patient's BP / Temp / Pulse :

d. Symptoms first appeared : _____ / ______ / __________

e. Date first consulted : __________ / __________ / __________

7.a. Any previous consultation / treatment / hospitalization for this symptom / illness or related conditions, or other disorders whether in this hospital or any other facilities?
☐ Yes ☐ No

b. Was this patient referred? If yes, please provide details below :

c. If this condition existed before symptoms became apparent to the patient, please indicate your professional opinion how long has the condition existed :

Date	Disease/ Disorder	Details of Treatment/ Hospitalization	Doctor / Hospital /Clinic

d. Can the condition be managed under the outpatient basis : ☐ Yes ☐ No
If no please provide reasons of admission :

8. a. ☐ Admitting Diagnosis :
Or
b. ☐ Provisional Diagnosis :

c. Diagnosis confirm on _______/ _______/ _________

d. Cause and pathology underlying the present diagnosis :

e. Any possibility of relapse? ☐ YES ☐ NO

Advised patient on _________ / _________ / ___________

9. Estimated Total Costs : RM

10.a. Admission requires :

☐ Hospitalization
☐ Day Care
☐ On Patient's request

11. Is the illness / condition related to : (please tick (√) if YES

☐ Pregnancy / Childbirth / Infertility / Caesarian section / miscarriage or any complications arising there from
☐ Congenital / Hereditary diseases
☐ Influence of drugs / alcohol
☐ Nervous / Mental / Emotional / Sleeping disorder
☐ Cosmetic reason / Dental care /refractive errors correction
☐ AIDS / HIV/ STD / VD
☐ Self - Inflicted injuries / Violation of laws / Strike/Riots
☐ None of the above

Please provide details

12. Medical treatment, investigation and surgical procedure to be performed, if any (please supply copy of all investigation results) :

13. Any other medical / surgical conditions present? ☐ Yes ☐ No, details below

a. ____since ______ / _______ / ________

b. ____since ______ /_______ / ________

14. Was the patient pregnant at the time of hospitalization? (for Female only)

☐ Yes ☐ No, __________ Months

15.a.If hospitalization was due to injury, please describe circumstances and cause of injury :

b. Please indicate date / time of accident : (dd/mm/yy) _________ / ________ / _________ (hrs) ___________ ☐ am ☐ pm

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

_________________________ ____ _________________________

Date

Name & Signature of Attending Doctor
DR's Contract no and email address

Doctor / Hospital Stamp

DISCHARGE SECTION (To Be Completed Upon Discharge by Doctor)

17. Undertaking Letter Ref No : (if available)

18. Date of Discharge : ________ / ________ / _________

19. a. Final Diagnosis :

b. Cause and pathology of the diagnosis :

20. a. Surgical procedures performed :

b. Date of surgery / procedure : ________ / ________ / _________

21.a. Recovery complication that arise (if any) :

b. In case of DEATH, please advise date/time and cause of death :

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

_________________________ ____ _________________________

Date

Name & Signature of Attending Doctor

Doctor / Hospital Stamp