[ប្រើសម្រាប់ទាមទារសំណង ករណីមរណភាព]

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របាយការគ្រូពេទ្យ
PHYSICIAN REPORT

របាយការណ៍គ្រូពេទ្យនេះ ប្រើក្នុងគោលបំណងជាឯកសារជំនួយដល់ការវាយតម្លៃ ចំពោះការស្នើសុំទាមទារសំណងចំពោះអ្នកត្រូវបានធានាប់រងខាងក្រោមតែប៉ុណ្ណោះ។
This physician report is used as supporting document to the insured below for claim assessment purpose only.

I. PATIENT INFORMATION

Full Name :	Date of Birth : ____/____/___	Gender: ☐Male ☐Female	Nationality: .....
ID Card or Passport Number:	Address:		

II.HOSPITAL & PHYSICIAN INFORMATION

Hospital Name:	Address:	
Attending Physician Name:	Specialty:	Contact Number: .....

Are you the attending physician, who provided treatment or consulted the above patient prior his/her death? ☐ YES ☐ NO

(If "NO", please provide reason :_____)

III.MEDICAL CONDITION AND DIAGNOSIS

1. **TYPE OF MEDICAL SERVICE *(Please tick one only)*:**

☐ **OPD** *(Outpatient)*	**Visit Date**: ____/____/___, **Time**: ____/____
☐ **IPD / ER** *(Inpatient Admission / Emergency)*	**Admission Date**: ____/____/___, **Time**: ____/____, **Discharged Date**: ____/____/___, Time: ____/____

2. **PRIMARY DIAGNOSIS:** .....(ICD-10: _____), **Date of Confirmed Diagnosis**: ____/____/___

   SECONDARY DIAGNOSES (if any): .....(ICD-10: _____), **Date of Confirmed Diagnosis**: ____/____/___

3. **Motifs of Admission / Presenting Complaint:**

   - **Chief complaint:** .....
   - **History of present illness:**

     .....

     .....

     .....
   - **Past Medical Illness (ACTD) and its duration from first discovery:**

     .....

     .....

     .....
   - **In your medical investigation, how long has the patient had this condition before the first consultation related to this admission/visit?**

     Date First Seen for This Condition: ____/____/___, Duration of having this illness: _____

     Basis for investigation *(clinical judgment, symptoms, test results, etc.):*

     .....

     .....
   - **Was above diagnosis a pre-existing disease before the current admission/visit?** ☐ **/YES** ☐ **/NO**

     If **"YES",** please explain your medical finding: .....

     .....

     .....

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4. PHYSICAL FINDINGS/PHYSICAL EXAMINATION: .....

.....

.....

.....

5. Para Clinical Findings:

- **Laboratory** .....
- **Ultrasound** .....
- **CT scan / MRI** .....
- **Other investigations** .....

6. Management (procedures, and treatment): .....

.....

7. Progression of Illness (Brief description): .....

.....

IV.DETAILED PAST MEDICAL HISTORY

8. Are you aware that she/he consulted or got treatment with another physician before your first visit with her/him? ☐ **YES** ☐ **NO**
if answered "Yes", please complete the information below)

Date of Attendance	Medical Institute name and address	Physician Name
____/____/____	.....	.....
____/____/____	.....	.....

9. Does the cause of above patient's death have any relation to the illness(es) or factor(s) below or not?

If answered "Yes", please complete the information here (How long the patient had these diseases or when first finding)

A) Hypertension	☐ **YES**	☐ **NO**	.....
B) Diabetes Mellitus	☐ **YES**	☐ **NO**	.....
C) Heart disease	☐ **YES**	☐ **NO**	.....
D) Cancer / Tumors	☐ **YES**	☐ **NO**	.....
E) Liver disease	☐ **YES**	☐ **NO**	.....
F) AIDS or HIV infectious	☐ **YES**	☐ **NO**	.....
G) Relate to any congenital disease or congenital anomaly	☐ **YES**	☐ **NO**	.....
H) Under influence of illegal drugs or stimulant substance or alcohol	☐ **YES**	☐ **NO**	.....
I) Mental illness/condition or Suicide	☐ **YES**	☐ **NO**	.....

10. Additional comments on the illness or factor above or others (if any):

.....

I hereby declare all the information filled in this physician report is sufficient and correct based on my experiences and knowledge.

Physician Signature	**Hospital Stamp**
Name: _____ Date: _____/_____/_____	Date: _____/_____/_____

Note: Please enclose copies of medical reports together with any test results or document proof of evidence on your declaration and necessary for assessment of the claim.