EXPAT & Co
International mobility insurances

ILLNESS / ACCIDENT MEDICAL REPORT

(PLEASE USE BLOCK CAPITALS)

Policy number _____

INFORMATION ABOUT THE PATIENT

First Name _____ Last Name _____

Address _____

_____

Postal Code _____ City _____ Country _____

Date of Birth _____ Gender ☐ M ☐ F

Email _____

Tel* _____ Mobile* _____

*please include country codes

DOCTOR'S DETAILS AND TREATMENT INFORMATION

Doctor's name _____

Address _____

Postal Code _____ City _____ Country _____

Tel* _____ Email _____

What date was the patient first aware of symptoms/condition? (dd/mm/yyyy) _____

First symptoms _____

Diagnosis _____

Has the patient previously suffered from the same complaints?

☐ No ☐ Yes, when (last time) _____

Brief description of treatment already given _____

Reason for referral for specialist treatment _____

_____

IN CASE OF HOSPITAL ADMISSION

Date of admission (dd/mm/yyyy) _____ Anticipated date of discharge _____

Name and address of **the hospital** _____

_____

Tel _____ Email _____

I declare that I am the patient's doctor and that the details given are, to the best of my knowledge, true and correct.

Date _____ Signature _____