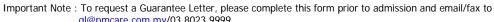
## **PMCare Pre-Admission Form**





gl@pmcare.com.my/0	)3 8023 9999.							PMCare	
Hospital Name									
Contact Person		Conta	act No.			Fax			
A.L		l							
Admission Date	day month		/ear	Admission T	ıme		am/pn	n	
5 4 4 4	PAIII	ENT INFOR	VIATION						
Patient Name									
PMCare Member ID									
Company Name									
Patient IC No./Birth Certificate No.	Date of Birl								
	PATIENT MEDICAL CONDITION								
					Blood	Blood Pressure			
Presenting symptoms at time of admission and physical finding	Pulse								
	Puis								
	<u>R</u>				Respir	piratory rate			
	Τe					nperature			
Is this the <b>FIRST TIME</b> patient has this/these or similar symptom(s)?	☐ Yes ☐ No						·		
If no, how long has the condition existed?	year(s)	_ month(s) _		_ week(s)		_day(s)			
	day month _	year							
When did patient first consult you									
for this complaint/condition?									
Provisional Diagnosis									
Etiology of the above diagnosis									
	Motor vehicle accident related		Vaa						
Please indicate (√) if the illness/injury or treatment is/are		□ No □	res	Date of accide	ent		day month	year	
	Slips, Trips or Fall	□ No □	Yes						
	Accident at Work		V	Time of accident			am/pm		
		□ No □	res						
						□ No	Yes		
						□ No	Yes		
	33.000					☐ No ☐ No	☐ Yes ☐ Yes		
							Yes		
						□ No	☐ Yes		
						□ No	☐ Yes		
						□ No	_		
Has patient suffered from/Is patient suffering any illnesses stated as follows:	Hypertension, Diabetes	□No	☐ Yes	Since?	•	day	month	year	
	Cardiovascular Disease	☐ No	☐ Yes	Since?		day	month	year	
	Malignancy of any kind	☐ No	☐ Yes	Since?		day	month	year	
	Stones of the Urinary system		Yes	Since?		day	month	year	
	ENT conditions		Yes	Since?			month	year	
	Hernias, haemorrhoids		Yes	Since?				year	
	Endometriosis Others		☐ Yes	Since?	day month year (If yes, please specify)			year	
	Others		☐ 163	Sirice:	(II yes,	, pieas	e specify)		
						day	month	year	
Can this condition be managed						uay	month	ycai	
under outpatient basis?	☐ Yes ☐ No (If no, please state reason)	Reason							
	, p								
Admission requires	☐ Hospitalisation ☐ Day Care ☐ On patient's request						Estimated length of stay	day	
Please state <b>TREATMENT PLAN.</b> e.g. lab test, imaging, and etc  Signature and stamp of Admitting	☐ Medication ☐ Diagnostic Imaging						Estimated total co	st	
	Procedure Laboratory Test								
	Surgery Others, Please specify:						RM		
	J								
Physician/Surgeon									
If Admitting Doctor is a Medical									
Officer, please state Name and									
Specialty / Doctor to be referred to									