

WITHOUT PREJUDICE



SBI LIFE INSURANCE COMPANY LIMITED

Certificate of Hospital Treatment

Part I

Please provide the details of the patient as per hospital records

Name of Patient (Life Assured): _____

Date of Birth: _____

Address _____

Occupation of the patient: _____

Date of Death: _____

Time of Death: _____

Part II

Name, Address and Telephone no. of referring doctor _____

What was the date of his/her admission into the hospital? _____

(a) The nature of his/her complaint? _____

The duration of the complaint as reported by him/her? _____

a) What was the exact history reported by the patient at the time of admission? _____

b) Was the history reported by patient himself/herself? _____

c) If not reported by the patient who reported the same? Was the patient at that time conscious?

d) Who recorded the history in the case sheet? _____

e) Tests conducted and results of the same for confirming the diagnosis _____

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Part III

What was the diagnosis arrived at in the hospital? _____

Treatment given _____

Duration of the treatment _____

Date of Discharge / death _____

If discharged, then condition of discharge and advice given for follow up

Part IV

Was there any other disease or illness which preceded or co existed with the ailment at the time of his/her admission into the hospital? If so what was it? Please provide history of such disease or illness stating.

[a] Date when the patient first observed such disease _____

[b] By whom treated _____

[c] By whom history reported to you _____

[d] Indoor Patient number _____

[e] Hospital Name and Address

Part V

Had the patient been admitted or treated by you or your hospital earlier Yes / No

If yes, Please provide the following details:

Date		Inpatient / Outpatient	Reason for seeking treatment	Treatment Given
From	To			

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Certified that the above information is correct as per records of the Hospital.

"The information is based on records maintained in the Register No. _____ Entry No. _____ dated _____"

Date: _____

Signature: _____

Name of Hospital : _____

Qualification: _____

Name of the Doctor : _____

Designation: _____

Address: _____

* Pls attached copy of Indoor case papers and death/discharge summary