SBI Life
Apne liye. Apno ke liye.

WITHOUT PREJUDICE

Certificate of Hospital Treatment

(a) Form to be filled in English only
(b) Kindly fill up the form complete in all respects and accompanied by Discharge Summary & other reports/documents
(c) Kindly be legible in filling up the form and ensure all information is declared correctly and clearly. DO NOT leave any column blank

Policy Number: Patient Registration No/IP No:

Part I

Please provide the details of the patient as per hospital records

Name of Patient (Life Assured):

Date of Birth: D D M M Y Y Y Y

Address

Date of Death: D D M M Y Y Y Y Time of Death:

Was he related? If Yes, how ☐ Yes ☐ No

Part II

Name of referring Doctor

Address & Telephone No. of referring Doctor

a) What was the date of his/her admission into the hospital? D D M M Y Y Y Y

(b) The nature of his/her complaint?

(c) The duration of the complaint as reported by him/her?

(d) What was the exact history reported by the patient at the time of admission?

(e) Was the history reported by patient himself/herself?

(f) If not reported by the patient who reported the same?

(g) Who recorded the history in the case sheet?

(h) Tests conducted and results of the same for confirming the diagnosis

Part III

What was the diagnosis arrived at in the hospital?

Treatment given

Duration of the treatment

Date of Discharge / death D D M M Y Y Y Y

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

Provide Discharge / Death Summary and Treatment Records/Papers for the above.

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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 — D D M M Y Y Y Y

[b] By whom treated

[c] Nature of Ailment

[d] Hospital Name and Address

[e] Phone No. of Hospital

[f] Indoor Patient number

[g] Was the Patient suffering from any physical or Mental disability and if yes, the details thereof

Part V

Had the patient been admitted or treated by you or your hospital earlier If yes, Please provide the following details: ☐ Yes ☐ No

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

Have you attached a copy of the Indoor case papers & death / Discharge Summary ☐ Yes ☐ No

If No, please provide reason

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: D D M M Y Y Y Y

Signature: _____

Name of the Doctor:

Qualification:

Registration No.

Designation:

Address of Hospital / Clinic:

Stamp of the Clinic / Hospital / Doctor

Contact No:

Provide Discharge / Death Summary and Treatment Records/Papers for the above.