



THC000101

Hospital Treatment Form: (Form-H)

Important Information:

1. This form is to be completed by the authorities at all the hospitals where the patient (Life Assured) was hospitalized
2. Please attach the patient admission sheet, investigations, history sheet, treatment records along with this form
3. One form is to be filled up per hospital/ nursing home

Please provide the following information based on the medical records and annex supporting documents

Policy no(s) _____

- i. Name of the Patient/ Life Assured _____
- ii. Age _____ years, Any mark of identification? _____
- iii. Date and Time of admission / / ; : (a.m. / p.m.) Admission no. _____
- ii. Was the patient (Life Assured) referred by any doctor/ hospital Yes No
If yes, then provide with the name and address _____
Contact no. _____
- iii. What were the complaints/ condition of the patient (Life Assured) at the time of admission

- iv. What was the exact nature and duration of the illness suffered by the patient (Life Assured)? (Please enclose admission notes)

- v. Was the history of illness reported by the patient himself? Yes No
If no, then by whom the history was reported _____
- vi. Name of the doctor who recorded the history with qualification _____
- vii. Did the patient (Life Assured) suffer from any past ailment as disclosed at the time of admission? Yes No
If yes, then provide details of the nature of the ailment and its duration:

- (*Annex supporting documents)
- viii. What was the diagnosis made at the hospital _____

- ix. What were the tests/ investigations undergone by the patient (Life Assured) at the hospital to confirm the diagnosis? (Please attach separate sheets if required)

- x. When was the diagnosis confirmed at the hospital?



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xi. What was the treatment given to the patient (Life Assured) during the hospitalization?

xii. Was/ were there any other contributory illnesses/ chronic ailments suffered by the patient (Life Assured) that existed at the time of admission? Yes No
 If yes, detail _____

xiii. What was the date of discharge from the hospital? / /

xiv. What was the condition of the patient (Life Assured) at the time discharge?

xv. Was the patient (Life Assured) treated at the hospital at any other occasion as an out-patient or inpatient? Yes No
 If yes, please provide details _____

xvi. Was the patient (Life Assured) treated by any other medical practitioner/hospital during the past 3 years? Yes No
 If yes then provide the details:

Name	Address	Contact No.

Certified that the above information is correct as per hospital records:

Date: / / Place _____ Signature: _____

Name and Designation of the Doctor: _____

Qualifications and Registration number of the Doctor: _____

Name of the Hospital: _____

Registration Number of the Hospital: _____

Address: _____

Telephone Number: _____

Seal / Stamp of the Hospital:

(Mandatory)