THC000101

Canara HSBC Oriental Bank of Commerce Life Insurance Co. Ltd.
2nd Floor, Orchid Business Park, Sector - 48, Sohna Road, Gurugram, Haryana, India – 122018

Treating Hospital Certificate

Form – H

Important Information:
1. This form is to be completed by the authorities at all the hospitals where the deceased 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 and Address of the deceased _____

ii. Age at Death years, Occupation _____ Any mark of identification? _____

i. Date of Death / / Time of Death : (a.m. / p.m.)

ii. Place of Death _____

i. Date and Time of admission / / ; : (a.m. / p.m.) Admission no. _____

ii. Was the deceased 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 deceased at the time of admission?

_____

_____

iv. What was the exact nature and duration of the illness suffered by the deceased ? (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 had recorded the history in the records

vii. Did the deceased 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 deceased 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 deceased during the hospitalization?

_____

_____

xii. Was/ were there any other contributory illnesses/ chronic ailments suffered by the deceased 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 deceased at the time discharge?

_____

_____

xv. Was the deceased treated at the hospital at any other occasion as an out-patient or inpatient? Yes No

If yes, please provide details _____

_____

xvi. Was the deceased 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 code of the Doctor:
Name of the Hospital:
Registration Number of the Hospital:
Address:
Telephone Number

Seal / Stamp of the Hospital: _____

(Mandatory)