# Medical Report For Gastro-Intestinal Tract Endoscopy *"Confidential"*

**IMPORTANT NOTE:**
Best Assistance Medical Controllers ask you to fill this form and answer all listed questions since; Only their completeness and comprehensiveness will allow the consideration of further coverage.
This form has to be filled by the **"Attending Physician"** when a Gastro Intestinal Tract Endoscopy is requested.

| **Administrative Information** | | | |
|---|---|---|---|
| **Patient's Full Name** | | **Provider** | |
| **Requested Endoscopy** | **Gastroscopy** ☐ **Colonoscopy** ☐ **Recto-Sigmoidoscopy** ☐ | **Date** | |

**Past Medical History (Mandatory)**

***Did your patient ever suffer or had been treated for any of the below systems?*** ☐**No** ☐**Yes**
***If yes, Kindly check which one/s and explain on the special explanatory paragraph***

| | | |
|---|---|---|
| ☐ Cardiovascular system / Hypertension | ☐ Genitourinary System (♀ & ♂) | ☐ Skin and Subcutaneous tissues |
| ☐ Diabetes / Endocrine System / Immunity | ☐ Musculoskeletal System | ☐ Congenital Anomalies |
| ☐ Neoplasm | ☐ Infectious Diseases | ☐ Mental Disorder |
| ☐ Digestive System | ☐ Blood and Blood forming Organs | ☐ Accidents & Injuries |
| ☐ Respiratory System | ☐ Pregnancy and Childbirth | ☐ Other: …… |

| **Diagnosis Description** | **Disease Starting date (Since when?)** |
|---|---|
| | |
| **Tests already done to diagnose your patient's disease?** | **Treatment (Medical / Surgical )** |
| | |

**Current Patient Situation**

| **What are the endoscopy's indications?** | **When did the patient's symptoms start (near exact date)?** |
|---|---|
| | |
| **Previous and recent drug treatments the patient received for G.I. disorders(Name and dose)** | **How did your patient respond to the treatments & results of relevant tests already undergone?** |
| | |

**Did the patient previously undergo any G.I. endoscopies? (Dates & results are required)**

| **Physician 's Section** | | | | | |
|---|---|---|---|---|---|
| **Name** | | **Date** | | **Signature & Stamp** | |

| **Patient 's Section** | | | | | |
|---|---|---|---|---|---|
| *أنا الموقع أدناه أفيد بأن المعلومات الواردة آنفاً الخاصة بي هي مطابقة للواقع ودقيقة وغير منقوصة. | | | | | |
| **Name** | | **Date** | | **Signature** | |