Best Assistance

# Medical Report For Admission *"Confidential"*

*To the kind attention of the attending physician,*
*In order to issue an approval of coverage for our clients, we need you to correctly complete this medical report and address it as extremely confidential to* ***Best Assistance*** *offices by fax to* ***01 – 422 200****. We thank you for your cooperation.*

## Administrative Information

| | | | |
|---|---|---|---|
| **Patient's Full Name** | | **Hospital's Name** | |
| **Admission Date** | | **Procedure 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 on the (Verso)*** → → → →

| | | |
|---|---|---|
| ☐ 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: …… |

## Present Illness

| | | | | | |
|---|---|---|---|---|---|
| **History of the Disease** | | | | | |
| **Preliminary Diagnosis** | | | | | |
| **Diagnostic Tests Already Done** | | | | | |
| **Requested Diagnostic Tests** | **Requested Tests / Pre Op** | | | | **Other tests** / **Requested Consultations** |
| | ☐ CBC | ☐ Urea | ☐ SGPT | ☐ Urine Analysis | ☐ **Other**: |
| | ☐ FBS | ☐ PT | ☐ SGOT | ☐ Chest X Ray | ☐ Cardiologist |
| | ☐ Creatinin | ☐ PTT | ☐ B. Group | ☐ EKG | ☐ **Other**: |
| | ☐ Ultrasound…… | | | | |
| | ☐ Scan…….. | | | | |
| | ☐ MRI…… | | | | |
| **Type of Admission** | ☐ Normal | ☐ Urgent | | | **Expected Hospital Stay** …… Day (s) |

## Case Management Plan

| | | | |
|---|---|---|---|
| ☐ **Medical** | | | |
| ☐ **Surgical** | **Code** | **Description** | **Anesthesia** |
| ☐ **Open** ☐ **Laparo/Endoscopic** | | | ☐ General ☐ Regional ☐ Local |

| | | | | |
|---|---|---|---|---|
| **Prosthesis/ Medical Supplies/ Laparoscopic Instruments/ Special Instruments/ Apparatus** ☐ **YES** ☐ **NO** (Orthopedic, Cardiologic, General surgery….) | **NSSF Code** (***If exists***) | **Description** | **Qty** | **Agent** *(in Lebanon)* |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | **Exp:** Stent / Drug Eluting Stent - Special Lens – Ligasure – Mesh – Staplers - T.V.T./T.O.T. - Patient Controlled Analgesia (PCA) - Laparoscopic Instrument - **External Fixator** - Coblation…… | | | |

## Physician's Information

| | | | | | | **Stamp & Signature** |
|---|---|---|---|---|---|---|
| **Full Name** | | | | **Specialty** | | |
| **Phone** | | **Mobile** | | **Date** | | |

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# Past Medical History Detail *"Confidential"*

***Very Important notification:***

***Failing to disclose any Past Medical History, will make our acceptance void and null, regardless of the pertinence of this medical history to the current case he is being treated for.***

| **Past Medical History Details** | | | |
|---|---|---|---|
| **Diagnosis Description** | | | |
| **At what age was your patient diagnosed with this disease or since when?** | | | |
| **What tests have been done to diagnose your patient's disease?** | | | |
| **Treatment** | **Medical** *(Drug Name & Dosage)* | | |
| | | | |
| | | | |
| | **Surgical** | | |
| | | | |
| | | | |
| **Has your patient been hospitalized for this condition?** | ☐ **No ---** ☐ **Yes, Please explain:** | | |

| | |
|---|---|
| **Treating physician's signature: ……** | **Date: ……/……/……** |

| **Patient's Section** | حقل مخصص للمريض |
|---|---|

***The undersigned asserts that the above information provided in respect of myself is complete, precise and true.**

***Je soussigné, affirme que les informations fournies ci-dessus sont vraies, précises et complètes.**

*أنا الموقع أدناه أفيد بأن المعلومات الواردة آنفاً الخاصة بي هي مطابقة للواقع ودقيقة وغير منقوصة.

| | |
|---|---|
| **Patient's Name:** …… | …… **اسم المريض:** |
| **Patient's Signature:** …… | …… **التوقيع:** |
| **Date:** …… | …… **التاريخ:** |