Clinical Information Request Form

Details

First Name (s) : Surname :

Medical Aid Option: Medical Aid No :

Date of Birth : Treating Doctor:

Planned Procedure/Reason for Admission:

Medical History :

Allergies :

Medication :

Surgical History :

Risk Factors :

Height : Weight : Temperature :

Blood Pressure : Pulse :

Cardio Vascular System :

Respiratory System :

Renal History :

Gastro-Intestinal System :

Investigations :

Blood Tests :

X-Rays :

Other Radiology :

ECG :

Treatment Plan :

Estimated Los :

Acknowledgement by Examinating Doctor

I certify that the particulars hereto are – to the best of my knowledge and belief – true and accurate, having conducted a personal examination and/or procured the tests and/or other diagnostic investigations referred to.

Signature of Medical Practitioner

Date

Place QR code/barcode or Stamp