Admission Notification Form *(all cases)*
THAMMASAT UNIVERSITY HOSPITAL
☐ Individual Insurance

Company Name.....
☐ Group Insurance

Part A

For Insured

1. Name-Surname of the Insured: ..... Gender: ・Male ・Female ID Card No.: .....
   Date of Birth: ..... Age: ..... Years ..... Months .....Occupation: .....
   Mobile Phone No.: .....Tel.: ..... Email: .....
   Current Address:.....
2. Policy No.: .....
   Do you have insurance policy with other companies? ・No ・Yes: Company ..... Policy No.:.....
3. Cause of claim
   ☐ Illness Symptoms: ..... Duration of symptoms before this treatment:.....
   Specify medical centers you have received treatment from before this treatment: ..... Date of treatment:
   .....
   ☐ Injury Date of injury: ..... Time : ..... Place of occurence: .....
   Cause of injury: .....
   Type and size of wound and injured organ: .....
4. For this accident, have you ever been treated anywhere? ☐ Never ☐ Yes, at .....When: .....
   by paying by yourself or using the medical benefits through the hospital amounting to ..... Baht

Consent Letter

I allow and give consent to doctors, medical centers, other insurance companies or related persons who have my personal data, health information, disability, sexual behaviors, biological data, race and health record, both at present and in the future, to disclose such information to the Company, the Company's life insurance agents, or the Company's representatives or insurance brokers or policyholders for the purposes of insurance application or policy benefit payment or any operations regarding insurance policies.

I give consent to the Company to collect, use and disclose my personal data, health information, disability, sexual behaviors, biological data, race and health record to agencies in authorities or reinsurance brokers or reinsurance companies, related persons, the Company's life insurance agents, personnel or representatives of the Company, or policyholders and/or insurance brokers for the purposes of insurance application or policy benefit payment or medical benefits or any operations regarding insurance policies.

In case of claiming through the hospital, I agree that the Company pays for the medical expenses to the medical centers where I have received this treatment and it should be deemed that the Company has duly paid medical expenses to me in accordance with the terms and conditions of the insurance policy. However, if there are any medical expenses that are outside the coverage of the insurance policy, I will pay directly to the hospital and I fully understand that the Company reserves the right according to the fax claim/credit claim agreement or other applicable agreements if it is found that my illness or accident is under the exclusion of the insurance policy even though the Company has accepted the inpatient hospitalization. In this case, if the Company has already made the advance payment to the hospital on my behalf, I agree to return all payments to the Company within 7 days of receiving notice from the Company.

In this regard, a copy of the consent letter shall have the same effect as the original.

I have acknowledged and understand the messages, terms and conditions of the Company under this document very well in detail. I agree that it is correct according to my intent. In this regard, I hereby agree to be bound by the conditions and practices of the Company in all respects.

Remarks:
***In case of a minor, a parent is required to sign and specify the relationship.**
****In case of signing by fingerprint, signatures of 2 witnesses must be completely provided.**

Insured: ..... Date: ..... Witness: ..... Witness: .....
(.....) Relationship: ..... (.....) (.....)
Grantor: ..... as a ☐ Father/Mother
☐ Legal representative of the insured (in case the insured is a minor)

For Hospital

1. Visit date: ..... Time: ..... Vital signs: T : ..... P : ..... R : ..... BP : .....
2. Chief complaint and duration: .....
3. Present illness or cause of injury: .....
   .....
   .....
4. Physical exam: .....
   .....
5. Previous treatment for this illness or injury (Date & Place): .....
6. Is the illness related to: (please tick ☑ if yes)
   ☐ Pregnancy / Childbirth / Infertility / Caesarean section / Miscarriage ☐ Congenital / Hereditary disease
   ☐ Nervous / Mental / Emotional / Sleeping disorder ☐ Influence of Drugs / Alcohol
   ☐ Cosmetic reason / Dental care / Refractive errors correction ☐ AIDS
   ☐ An accident; Date of accident: ..... Time: .....
7. Underlying condition: .....
8. Provisional diagnosis: ..... AdjRW=.....
9. Can the condition be managed under Out Patient basis ○ Yes ○ No
   (If No, please provide more information).....
10. Reasons of admission .....
11. Plan of treatment .....

Physician's name ..... Medical license No. ..... Specialty .....

(.....) Date. .....

Discharge Notification Form

Company name.....

THAMMASAT UNIVERSITY HOSPITAL

Part B

Medical certification

Patient's Name: ..... Sex ○ Male ○ Female HN : ..... AN: .....Age..... Year(s) .....Month(s)

Admission Date: ..... Time: ..... Discharge Date: ..... Time: ..... Consultation Date: .....

1. For Illness

a) Date you first saw this patient for this illness: .....

.....

.....

b) Chief complaint and duration of symptom(s):

.....

.....

.....

.....

.....

.....

2. For Injury

a) Date of injury..... Time: .....

b) Cause of injury.....

c) Details of injury .....

d) Did you smell alcohol from the patient?

( ) No ( ) Not known

( ) Yes**,** blood alcohol test (if any) = ... mg%

e) Level of consciousness ( ) Normal ( ) Confusion

( ) Drowsiness ( ) Semi-coma ( ) Coma

f) Estimated time for recovery

.....

.....

3. Did the patient need to be admitted to hospital? ( ) No ( ) Yes, indication for admission.....

.....

4. Vital signs: T..... P..... R ..... BP.....

5. Pertinent Clinical findings (Symptoms & Signs) .....

.....

6. Investigation & Result (Lab, EKG, X – ray, etc.) .....

.....

7. HIV Test ( ) No ( ) Yes, Result : ..... Date performed: .....

8. Underlying disease: .....

9. Diagnosis 1: .....ICD10-TM: .....

Diagnosis 2: .....ICD10-TM: .....

Diagnosis 3: .....ICD10-TM: .....

Adjusted RW	

10. Treatment: .....

.....

11. Surgery/Operation: ..... ICD9-CM: ..... Date performed: .....

Anaesthesia Type: ( ) General Anaesthesia ( ) Spinal Anaesthesia ( ) Local Anaesthesia ( ) Others .....

12. Pathological report: .....

13. Complications (if any): .....

14. Is the illness related to alcohol, drug abuse or addiction? ( ) No ( ) Yes, please specify .....

15. For Female: Is the patient pregnant? ( ) No ( ) Yes, gestational age ..... weeks

Was the treatment related to infertility? ( ) No ( ) Yes, please specify .....

16. Has patient ever been treated by another doctor before? ( ) No ( ) Yes, please give name and address .....

17. Was the illness/injury contributed to or influenced by any of the following

a) Physical defects/congenital anomaly ( ) No ( ) Yes

b) Degenerative change(s) ( ) No ( ) Yes

18. Others past medical history

Date	Signs & Symptoms	Diagnosis	Treatment	Hospital

19. Other comments about the injury / illness.....

.....

I, hereby certify that I have personally examined and treated the insured in connection with the disability and that the facts are in my opinion as given above.

Physician's Signature ..... Medical Specialty: ..... Thai Medical license No: .....

(.....) Tel.: ..... Date: .....

Medical Institute: ..... Address: .....

Remark: A physician who issues this report must be licensed to practice medicine and duly registered by the Thai Medical Council.