

**PHYSICIAN ATTENDING REPORT**

<b>TO</b>	Aetna Health Insurance (Thailand) Public Company Limited. Tel. 02-677-0000 Fax. 02-230-6552	<b>FROM</b>	Hospital..... FAX..... Room.....
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Patient's Name:.....HN.....AN.....  
 Admission Date .....Time..... Discharge Date.....Time.....

**Please give detail relating to this treatment** **\*Please use medical terminology**

**For Illness:**

1. Date you first saw this patient for this illness: .....
2. Chief complaint and duration of symptoms.....
3. In your opinion, how long should this symptoms persist for this illness.....

**For Injury:** 1. Date & time of injury .....Date & time you first saw this patient.....

2. Cause of injury.....  
Nature of wound and injured organs.....
3. Did you smell alcohol from the patient? No Yes Not known  
Level of consciousness Normal Confusion Drowsiness Semi-coma Coma  
Did the patient take any medication, drugs? No Yes (ชื่อ/ชนิด ของยา) ..... Not known

Pertinent clinical findings (Symptoms & Signs).....  
 .....  
 Underlying diseases.....  
 Investigations / pathological studies.....  
 .....

**Diagnosis 1** ..... **ICD10** .....

**Diagnosis 2** ..... **ICD10** .....

**Diagnosis 3** ..... **ICD10** .....

(Please fill the diagnosis that treated on this admission, not including the underlying diseases or conditions not treated: please ranking from the most important Dx to the less one)

**Treatment**.....  
 .....

**Surgery / Operation** ..... **ICD9 / CPT** .....

**Result / Complications**.....

- Is the illness related to alcohol, drug abuse or addiction? No Yes..... Not known
- For Female is the patient pregnant? No Yes Gestation age .....Wks
- Was the treatment relate to infertility? No Yes.....
- HIV Not done Done Result.....
- Has patient ever been treated by other doctors before? No Yes, please give name and address.....

**Past History**

Date	Signs & Symptoms	Diagnosis	Treatment	Physicians

For accident: Estimated time for recovery.....  
 Other comments.....

Signature (.....)	Medical License No..... Date .....
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