Annex A

Letter of Certification

☐ Medisave ☐ Non-Medisave

To

Hospital / Clinic Administrator

_____ Hospital / Clinic

PARTICULARS OF PATIENT

(a) Name of Patient: _____

(b) NRIC/Passport No.: _____

(c) Patient A/C No.: _____

(d) Date of Admission: *(dd)* *(mm)* *(yy)* ☐☐ ☐☐ ☐☐

(e) Date of Discharge: ☐☐ ☐☐ ☐☐

(f) Case-type : ☐ Inpatient ☐ Day Surgery

(g) Speciality :

☐ 01 Burns	☐ 13 Infectious Disease	☐ 25 Plastic & Recontructive Surgery
☐ 02 Cardio Thoracic Surgery	☐ 14 Neonatology	☐ 26 Psychiatry
☐ 03 Cardiology	☐ 15 Neurology	☐ 27 Rehabilitation Medicine
☐ 04 Chronic Medicine	☐ 16 Neurosurgery	☐ 28 Renal Medicine
☐ 05 Dental	☐ 17 Nuclear Medicine	☐ 29 Therapeutic Radiology
☐ 06 Dermatology	☐ 18 Obstetrics	☐ 30 Trauma
☐ 07 General Surgery	☐ 19 Medical Oncology	☐ 31 Tuberculosis
☐ 08 General Surgery	☐ 20 Opthalmology	☐ 32 Urology
☐ 09 Geriatic Medicine	☐ 21 Orthopaedic Surgery	☐ 33 Colorectal Surgery
☐ 10 Gynaecology	☐ 22 Otorhinolaryngology	☐ 99 Others *(please specify)*
☐ 11 Haematology	☐ 23 Paediatric Medicine	
☐ 12 Hand Surgery	☐ 24 Paediatric Surgery	_____
		_____

I.

I certify that it was necessary for the above-named patient to be treated as an inpatient or for the day surgery for the following medical condition(s) :

FULL DESCRIPTION OF DIAGNOSIS

(a) Final Diagnosis *(Principal Morbid Condition)* :

_____

_____

_____ ☐☐☐☐

(b) Other Diagnosis *(if applicable)* :

i _____

_____ ☐☐☐☐

ii _____

_____ ☐☐☐☐

(c) Cause of Injury *(to be completed for all cases where the diagnosis is injury or poisoning)*

_____

_____

E ☐☐☐☐

(d) For Obstetric Cases only :

No. of Living Children *(excluding present live birth)* ☐

II.

I further certify that the patient had undergone the following operations *(if applicable)* :

	Date of Operation/Procedure *(dd) (mm) (yy)*	Surgical Operation/Procedure	Operation Code	Table
(a)				
(b)				
(c)				

III.

If any of the operations above are listed in the currently established list of Cosmetic Surgeries, please indicate whether the operation(s) was done for :

☐ Cosmetic Reasons ☐ Medical Reasons *(please specify)* : _____

_____

IV.

If the procedure is a staged operation, please indicate below whether it is performed for medical reasons:
(A staged operation for a single condition will only be allowed to be claimed as a single operation)

☐ Staged Operation for medical reasons

V.

Outcome:

(Hospital) ☐ Patient Discharged ☐ Transferred to :

☐ Absconded ☐ Died

VI.

(a) Drug Allergy:

Drug Code (for Official Use only)	*Text*	*System*	*Route*	*Probability*
Reaction				

(b) Medical Alert Data:

Diabetic Therapy	☐ Y – Yes	☐ N – No	
G6PD Deficiency	☐ Y – Yes	☐ N – No	☐ U – Unknown
Asthma	☐ Y – Yes	☐ N – No	
Steroid Therapy	☐ Y – Yes	☐ N – No	
Anti-Coagulant Therapy	☐ Y – Yes	☐ N – No	
Blood Transfusion Reaction	☐ Y – Yes	☐ N – No	☐ U – Unknown

(c) Doctor Reporting Drug Allergy / Medical Alert Data :

Name: _____ Date: _____ MCR No. ☐☐☐☐☐☐

Codes for completion of items under "Drug Allergy" :-

System involved:
- AN – Anaphylaxis
- CH – CNS
- CV – CVS
- SK – Skin
- GI – GIT
- HA – Haematology
- LI– Liver
- LU – Lungs
- RE – Renal
- OO – Others
- XX – Unknown

Route of Administration
1. Topical
2. Parenteral
3. Oral
4. Others
5.Unknown

Probability
1. Definite
2. Unconfirmed

Type of Reaction
1. Major
2. Minor
3. Unknown

(a) _____ | | | | | | |
Principal Doctor / Surgeon / Dentist

(b) _____ | | | | | | |
Other Doctor / Surgeon / Dentist

(c) _____ | | | | | | |
Other Doctor / Surgeon / Dentist

(d) _____ | | | | | | |
Other Doctor / Surgeon / Dentist

(e) _____ | | | | | | |
Anaesthetist *(if any)*

(f) _____
Foreign Visiting Doctor *(if applicable)*
(Management period was from: _____ to _____)

Inpatient/ Attendance Consultation Fees	Operational Procedure Fees	Other Fees	Total Fees
$	$	$	$
$	$	$	$
$	$	$	$
$	$	$	$
$	$	$	$
Total			

VII.

I certify that the total doctors' / dentists' fees incurred from all sources in the management of the patient during this episode were :

Name of Doctor / Dentist MCR / DBR No.

VIII.

I hereby certify that the above information is correct. (please tick in appropriate box)

☐ I authorize the hospital / clinic to make claims to Medisave / Medishield on my behalf.

☐ No Claims from Medisave / Medishield is necessary.

_____ _____

Signature of Principal Doctor Date

Please include all charges for medications, consumables and supplies etc. levied by the doctor(s) in relation to their management of this patient during this inpatient / day surgery episode