PMCare Pre-Admission Form

Important Note : To request a Guarantee Letter, please complete this form prior to admission and email/fax to:
gl@pmcare.com.my/03 8022 3000.

Hospital Name					
Contact Person		Contact No.		Fax	
Admission Date	day month year		Admission Time	am/pm	

PATIENT INFORMATION

Patient Name			
PMCare Member ID			
Company Name			
Patient IC No./Birth Certificate No.		Date of Birth	

PATIENT MEDICAL CONDITION

Presenting symptoms at time of admission and physical finding		Blood Pressure	
		Pulse	
		Respiratory rate	
		Temperature	

Is this the **FIRST TIME** patient has this/these or similar symptom(s)?	☐ Yes ☐ No
If no, how long has the condition existed?	__________ year(s) __________ month(s) __________ week(s) __________day(s)
When did patient first consult you for this complaint/condition?	_______ day _______ month _______ year
Provisional Diagnosis	
Etiology of the above diagnosis	

Please indicate (√) if the illness/injury or treatment is/are				
	Motor vehicle accident related	☐ No ☐ Yes	Date of accident	______day _____month ______year
	Slips, Trips or Fall	☐ No ☐ Yes	Time of accident	am/pm
	Accident at Work	☐ No ☐ Yes		
	Cosmetic/Dental Care/Refractive error			☐ No ☐ Yes
	Chronic Illnessess			☐ No ☐ Yes
	Influence of Drugs/Alcohol			☐ No ☐ Yes
	Psychological Disorder/Psychiatric/Sleeping Disorder			☐ No ☐ Yes
	Pregnancy Related /infertility			☐ No ☐ Yes
	Self-Inflicted injuries/Violation of laws/Strike/Riots			☐ No ☐ Yes
	Congenital			☐ No ☐ Yes
	STD/HIV/AIDS			☐ No ☐ Yes

Any other medical/surgical condition present?	☐ No ☐ Yes, details below: a) ______________________________since___/___/___ b) ______________________________since___/___/___ c) ______________________________since___/___/___ d) ______________________________since___/___/___	Was the patient pregnant at the time of hospitalization? (for female only). ☐ No ☐ Yes, ________months.
Can this condition be managed under outpatient basis?	☐ Yes ☐ No. If no, please state reason for admission/daycare;	

Admission requires	☐ Hospitalisation ☐ Day Care ☐ On patient's request	**Estimated length of stay:**	**Estimated total cost:** **RM:**
Please state **TREATMENT PLAN.** e.g. lab test, imaging, and etc			

Signature and stamp of Admission Doctor/Hospital	If Admitting Doctor is a Medical Officer, please state Name and Specialty / Doctor to be referred to: