MEDICAL STATEMENT

BAF Med**Safe** Secure Care • BAF Med**Safe** Critical Care

To be completed by the treating physician (PLEASE USE BLOCK LETTERS)

1. PATIENT'S INFORMATION

Name					
Date of Birth		Height	☐ M ☐ Ft	Weight	☐ Kg ☐ Lb

2. MEDICAL HISTORY

Please provide details of when the condition was diagnosed:

Date of first visit	Symptoms	

Diagnosis

Prognosis

Treatment

Other comments

Have you referred the patient to another specialist or hospital, or know of treatment rendered elsewhere? ☐ Yes ☐ No If "Yes", please fill out the information requested below.

Physician's name		Telephone	
Outpatient treatment			
Hospital		Telephone	
Hospital treatment			

3. TREATING PHSYCIAN S INFORMATION

Name			
Address			
Telephone		Fax	
Email			
Signature		Date	