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:											
	tails of when t		diagnosed:								
Date of first visit		Symptoms									
Diagnosis											
Prognosis											
Treatment											
Other comments											
Have you referred	I the nationt to	another specialis	st or hospital	or know o	of treatment rende	arad alsawhar	a? \(\text{Vac}	No If "Ves" n	lease fill out th	ne information re	anuestad
below.	tile patient t	o another specialis	st of Hospital,	OI KIIOW C	i treatment rend	erea eisewrier	e: 🗌 les	□ No II Tes , pi	lease IIII Out ti	ie illioilliatioil re	equesteu
Physician's name					Telepho	ne					
Outpatient treatment											
Hospital					Telepho	ne					
Hospital treatment											
a cathrent											
3. TREATING PH	SYCIAN S IN	FORMATION									
Name											
Address											
Telephone					Fax	K					
Email											
Signati	ure							Date			