

Part 3: Medical Report (TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SURGEON)

For admissions to Private Hospital or Hospitals outside Singapore, Claimant must arrange to have this section completed by the attending Physician / Surgeon when submitting a claim. Any fees charged for the completion of this section shall be borne by the Claimant.

1. Policy No. G0009376	2. Name of Company HITACHI VANTARA
3. Name of Patient BOJJIREDDY SOUJANYA	4. NRIC/ Passport No. S8477350F
5. Date of Birth (DD / MM / YYYY) 25/08/1984	6. Date of Admission (DD / MM / YYYY) 04/12/2025
7. Date of Discharge (DD / MM / YYYY) 06/12/2025	8. Name of Hospital SRI LAKSHMI MULTI SECIALITY HOSPITAL
9. Date of First Consultation (DD / MM / YYYY) 04/12/2025	10. Final Diagnosis Description (ICD 10) ABNORMAL UTERINE BLEEDING
11. Final Diagnosis Code (ICD 10) Abnormal uterine bleeding	12. Date of Diagnosis (DD / MM / YYYY) 04/12/2025
13. What is the cause of illness / injury? NA	14. What is the anatomy of this illness? NA
15. Details of Operation(s) / Surgical Procedure(s) performed (a) Date when it was performed (DD / MM / YYYY) 04/12/2025 (b) Type of Operation(s) / Surgical Procedure(s) (c) Operation Code(s)* Emergency Hysteroscopic Guided (d) Operation Table(s)* Polypectomy, Fractional Curettage and Mirena Insertion. *For surgeries done in Singapore and based on Tables of Surgical Procedure for MediSave Scheme 1 February 2014	16. Were the surgical procedures approached through the same incision? ☐ No ☐ Yes NA
17. Please indicate the treatment rendered if no surgery was done. NA	18. Please advise the period of medical leave given.
19. Has the patient had any prior treatment for this condition? ☒ No ☐ Yes - Please state the date of treatment, name & address of doctor who treated the patient	20. Was the patient referred by another doctor? ☒ No ☐ Yes - Please furnish the name and address of the referring doctor

Was the above condition discovered during your investigation of his / her fertility condition?

- ☒ No
☐ Yes

22. Is the condition / treatment related to:
(“Circle” the relevant response)

- a. Pregnancy or childbirth (Yes / No) ☒
- b. Infertility or Sub-fertility Condition (Yes / No) ☒
- c. Congenital Anomaly (Yes / No) ☒
- d. Genetic or Chromosomal Disorder (Yes / No) ☒
- e. Mental, Nervous, Emotional or Psychiatric Disorder (Yes / No) ☒
- f. Cosmetic Surgery (Yes / No) ☒
- g. Correction of short-sightedness (Yes / No) ☒
- h. Abortion / Miscarriage / Impotency Sterilization (Yes / No) ☒
If related to miscarriage, was it due to accident (Yes / No) ☒
- i. Sexually Transmitted Disease / AIDS, or any other illness or Disease related to HIV (Yes / No) ☒
- j. Self-inflicted injury / Drug Addiction / Alcoholism (Yes / No) ☒
- k. Sleep Apnea / Obesity / Weight reduction or Improvement (Yes / No) ☒
- l. Dental / gum treatment or oral mucosal (Yes / No) ☒

If “Yes” to any of the above, please provide further details below:

23. Please provide the approximate date of discovery of the illness or injury (DD / MM / YYYY)

04/12/2015

24. How long has the illness / injury existed prior to consulting you?

3 months

25. Did the patient experience any symptom(s) prior to consulting you?

- ☐ No
☒ Yes - Please indicate the nature of symptom(s) and date when symptom(s) first started

3 months

26. If an excision was performed, please indicate the size of the lesion / tumor (Please attach a copy of the Histology Report).

NA

27. Please provide name(s) of the following:

(a) Attending Physician

(b) Surgeon

Dr. K. Padma Reddy.

(c) Anaesthetist

Dr. Hari prasad.

28. If there are no symptoms / complaints, what had prompted the patient to see you?

NA

29. Has the patient ever had a similar condition / symptom?

- ☒ No
☐ Yes
☐ Not to my knowledge

30. Doctors previously consulted by the patient for the above condition.

(a) Name of Doctor: Dr. K. Padma Reddy

(b) Date of First Consultation:

(c) Name & Address of Clinic: SRI LAKSHMI HOSPITAL

1-5-39/2, Behind Ashmi Supermarket,
New Town, Mahabub Nagar

31. Is the patient still under your care for this condition?

☐ No - Please provide the following:

1. Date when follow-up was terminated

2. Name and address of doctor (if the patient was referred to another doctor for follow-up)

☐ Yes - Please state the estimated duration that patient needs to follow-up with you

32. Was the hospitalization / procedure for investigative purposes?

☒ No

☐ Yes - Please provide further details:

33. Is this a job-related injury?

☒ No

☐ Yes - Please provide further details:

34. If this condition had existed before symptoms became apparent to the patient, please indicate (in your view) when this condition began to develop.

Signature of Physician / Surgeon

Dr. K. Padma Reddy

MEDICAL DIRECTOR.

Name / Designation

Date

12/01/2016

SRI LAKSHMI HOSPITAL

SRI LAKSHMI HOSPITAL

Regd. No. 161/2009

1-5-39/2, New Town,

MAHABUBNAGAR - 509 001

Name and Address of Clinic / Hospital & Stamp