

To be completed by the physician. Any professional fees charged are the insured's responsibility.

Contract Number

### Patient Information

Name <span style="float: right;">First name</span>	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth <small>year      month      day</small>
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### Information Concerning the Accident or Illness

Diagnosis or nature of the injury or illness: \_\_\_\_\_

Date the accident happened or first symptoms of the illness appeared: year      month      day

Date of first consultation: year      month      day

Has this person ever suffered from this illness before?  Yes  No

If so, please specify the date: year      month      day

Was the patient hospitalized due to this condition?  Yes  No

If so, please specify the dates: year      month      day to year      month      day

List all visits and/or treatment dates for this condition from initial consultation to present:  
year      month      day    year      month      day    year      month      day    year      month      day

Is this condition the complication of an underlying condition?  Yes  No

If so, please specify: \_\_\_\_\_

Was this patient referred to you by another doctor?  Yes  No      Name and address of the referring doctor: \_\_\_\_\_

If so, specify the referral date: year      month      day

### Medical Recommendation as to the Capacity of Travelling

Is this patient the person travelling?  Yes  No

If so, was this patient unable to travel due to this illness or injury?  Yes  No

Indicate the date on which you recommended the trip be cancelled: year      month      day

Dates recommended not to travel: year      month      day to year      month      day

Are there any other reasons why this patient should not travel? \_\_\_\_\_

### Comments

### Physician Identification and Signature

Name and address of the physician (Please print): _____	Physician's stamp
Specialty: _____ Telephone: _____	
Date: <small>year      month      day</small> Signature of the physician: _____	

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