Information in English Only

Patient Information

(To be filled in by Medical Practitioner/Treating Hospital)

Date:______________

Name: ____________________________________ Age:__________ Sex: __________

Address: ____

____

State: ____________________ Country: __________________ City: _____________

Fax: _________________ Email: _____________________ Mobile: _______________

Patient History

Chief Complaints:

Past History:

Investigations:

Diagnosis:

Treatment Taken:

Further treatment modalities sugested :

Name of consultant :

Signature of consultant

NB: Kindly attach all medical reports of the Patient with this form

IRIS HOSPITAL

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