MEDICAL REPORT CONSENT AND APPLICATION

Instructions

1. This form must be fully completed for the application of a medical report and shall be signed by the patient and requestor. The completed form is valid for a period of 6 months from the signed date.
2. If request is made by a guardian/parent, proof of relationship to the patient must be provided. Where the patient is incapable of authorising the request, supporting documents to substantiate this claim must also be attached. Photocopies of relevant documents (e.g. NRIC, birth certificate, and letters of administration) are to be included where applicable.
3. This form is to be submitted with the required report fee plus delivery charges if applicable. Please note that payment is non-refundable should the requestor choose to cancel the application.
4. The release of the medical report is subject to the approval and discretion of National University Polyclinics.

Requestor's Details

Please indicate your relationship to the patient based on the selections provided below:

- ☐ Patient (self)
- ☐ Parent/Guardian of Minor (where patient is below 21 years of age)
- ☐ Patient's Appointed Estate Administrator (if patient is deceased)
- ☐ Patient's Appointed LPA Donee (where patient is incapable of authorising the request)
- ☐ Others/ Authorised Representative (please specify): _____

Patient's Particulars

Given Name (As in *ID/Birth Cert/Passport): _____ ID No.: _____

National University Polyclinics: _____ (To Specify Clinic Location)

Date(s) of Clinic Attendance (for which this application for medical information is to cover):

_____

Consent by Patient / Legal Representative

I, _____ (Name), ID no. _____ hereby authorize National University Polyclinics to furnish and release the chosen report below:

- ☐ Ordinary Medical Report
- ☐ Duplicate Copy of Medical Report
- ☐ Completion of Insurance Form (please attach a copy of insurance claim or insurance proposal form)
- ☐ Others (please specify): _____

For:

☐ Myself ☐ My Dependent: _____ (Please specify relationship) ☐ My Estate ☐ My Donee

To: Authorised Representative (Indicate NA if not applicable)

Name of *Company/ Person: _____

Address of *Company/ Person: _____

For the purpose of: _____

Besides the medical report fee, I agree to pay for any additional charges, such as X-ray and Laboratory Investigation Charges, which may be incurred in the preparation of the medical report.

_____

Signature of Patient / Legal Representative & Date

Preferred Mode of Delivery/ Collection

☐ **Self-collect by Requestor:** I will personally collect the report once it is ready. I understand that I must produce my ID for staff verification, otherwise the medical report cannot be released.

Following to be filled during Collection

Collected by: _____ *[Name & Signature of Requestor]*

Date collected: _____ *Verified by:* _____ *[NUP staff]*

☐ **Collection by Authorised Representative:** The report will be collected by my authorised representative. I understand that he/ she must produce the required documents upon collection before medical report can be released - Please complete "Authorisation for Collection of Medical Report" form.

☐ **Registered/ Courier Mail:** The report will be sent to the address of Requestor by *^ Registered mail/ Courier. Mailing Address: _____

☐ **Email:** The report will be sent to Requestor's email address: _____ and password will be communicated via SMS/call at the #mobile number provided: _____

_____ _____

Name of Requestor (in BLOCK LETTERS) Signature of Requestor & Date

*Delete as appropriate
^Additional charges may apply for sending of report through registered mail/courier
#Mobile number is used to receive password for accessing the soft copy file, where applicable.

National University Polyclinics

For NUP Use

Medical Report Reference No.: _____

Medical Report Request Verification

☐ *Patient/Parent//Deputy/LPA done/Estate Admin etc → ☐ Documents Provided/ Verified → ☐ Payment received

Sighted by: _____ (Cheque No.: _____)
Date/ Time: _____

☐ Others (e.g. NOK/ 3rd party/ etc.) → ☐ Phone verification with patient on Medical Report request → ☐ Payment received

(Cheque No.:_____)

Called by: _____
Date/ Time: _____

☐ Documents Provided/ Verified

Sighted by: _____
Date/ Time: _____

Movement of Medical Report

Drafting Doctor: _____ Name, Signature & Date (PLEASE RETURN BEFORE DDMMYYYY)

Vetting Doctor: _____ Name, Signature & Date (PLEASE RETURN BEFORE DDMMYYYY)

Medical Report Release Checklist

☐ Softcopies of Medical Report are password protected in share point (both Ops & Dr drafts)

☐ Patient's name and ID. no on Medical Report tallies with patient's record in EPIC

☐ Prepare a duplicate copy of Medical Report for digital archival into patient's EPIC record

☐ [For Email Delivery] Medical Report that is to be emailed to requestor has been encrypted in accordance with NUHS's password recommendation.

Medical Report emailed on: _____ by _____ (Ops Staff).

Password communicated on: _____ by _____ (Ops Staff).

☐ [For *Registered/ Courier** Mail]

☐ Step 1: Requestor's mailing address written on envelop to OSS tallies with mailing address provided by requestor on consent form.

☐ Step 2: Ops staff to confirm that requestor's mailing address on Singpost posting form (scan provided by OSS Staff) tallies with mailing address provided by requestor on consent form. Medical Report sent via *Registered/ Courier** Mail on: _____ by _____ (OSS Staff).

Checked by: _____ Ops Staff Name & Signature _____Date/Time

Verified by: _____ OM/ OE Name & Signature _____Date/Time