

	معلومات شخصية عن المريض معلومات عن التاريخ المرضي				
8	Kidney disease مرض الكلى				
9	Cancer السرطان				
12	History of surgery التاريخ الجراحي				
13	Other illnesses أمراض أخرى				

Current medication (Long term)

أدوية المريض (طويلة الأمد)

I hereby certify that the information provided above is true and accurate. I acknowledge that providing false information may result in me being deemed unfit to travel.

Date

Signature of Customer

SECTION 2 - PHYSICAL EXAMINATION

To be filled by examining doctor

1. BASIC MEASUREMENT			
Temperature:	Blood pressure (mmHg):		
Pulse rate: (/ min)	SPO2:		
2. GENERAL EXAMINATION			
Pallor <input type="checkbox"/>	Cyanosis <input type="checkbox"/>	Jaundice <input type="checkbox"/>	Oedema <input type="checkbox"/>
3. SYSTEMIC EXAMINATION			
ITEM	NORMAL	ABNORMAL	COMMENT
e. Cardiovascular system			
f. Respiratory System			
g. Abdomen / hernia Orifices			
h. Nervous System			
Other systems (Please state the system which is abnormal in the comments with details)			

SECTION 3 - INVESTIGATIONS



URINE Analysis		Date Taken	
ITEM	Normal/abnormal	(if abnormal write the abnormal value)	
Urine RE			
BLOOD TEST		Date Taken	
Hemoglobin/HCT: _____ TLC: Neutrophil %: Platelet:			
Na/K: Creat:..... PT/INR: AST/ALT:.....			
Others:.....			
CHEST X-RAY and ECG INFORMATION	Normal	Abnormal	Comment
Chest X-ray:			
ECG			

SECTION 4 - CERTIFICATION BY THE EXAMINING DOCTOR

Please tick (✓) in the relevant box

I certify that I have on this date _____ examined

Mr / Ms _____ ID No. _____

and found him / her :-

The above named Patient is fit to travel

The above named patient requires further investigation or follow-up to determine their fitness to travel. (Write details)

The above named Patient require wheelchair.

Date: _____

Signature of Doctor : _____

Name of Doctor (with Qualification) : _____

Registration Number : _____

Name of the Hospital: : _____

Official stamp : _____

