Treatment History Statement

for Critical Illness Evaluation

Patient Information

Full Name

Date of Birth (DD/MM/YYYY)

Gender

Medical Record Number

Contact Number

Diagnosis Details

Primary Critical Illness Diagnosis

Date of Diagnosis

Treatment History

Summary of Treatments Received

Dates and Duration of Hospitalization(s)

Surgeries / Procedures (if any)

Medications and Therapies

Treating Physician(s) / Facility

Additional Notes

Patient / Guardian Signature

Date: _____

Physician Signature

Date: _____