Grupo Nacional Provincial, S.A.
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Medical Report

The treating physician must complete this form in block capitals and sign it. Please do not leave any blank spaces. This document will not be valid if it has any deletion or erasure and no subsequent changes will be accepted.

Procedure		
☐ Programming of surgery	☐ Programming of medical treatment	☐ Refunds

Identification Details				
Patient's Name				**Date of birth**
Paternal Surname	Maternal Surname	Name(s)		Month Day Year
Sex ☐ M ☐ F	Age	Policy No.	Reason for treatment ☐ Pregnancy ☐ Illness ☐ Accident	

Clinical Record (specify time of condition)	
Personal pathological background	Personal non-pathological record
Gynecological-obstetic record	Perinatal record (if necessary)

Current condition		
Please specify the date on which the condition commenced, based on the clinical record and natural evolution of the illness		Start Date Month Day Year
ICD Code	Final diagnosis	Diagnosis Date Month Day Year

Type of condition				
☐ Congenital	☐ Acquired	☐ Acute	☐ Chronic	Have you suffered from any other condition? ☐ Yes ☐ No Which?
Result of physical examination and studies carried out (attach interpretations that confirm diagnosis)				