CYPRIALIFE
Registr.No. .46532 – Private
17, Acropoleos Str., 2006 Strovolos
Tel. 22 11 12 13

HOSPITAL OR CLINIC CERTIFICATE

To be completed by the attending physician only:

NAME OF HOSPITAL OR CLINIC ADDRESS TELEPHONE NO.

……

PATIENT'S FULL NAME ADDRESS TELEPHONE NO.

……

ATTENDING PHYSICIANS

A. ……………………………………………………………………………… B. ……………………………………………………………………………

DETAILED DIAGNOSIS ………

WAS A SURGERY TAKEN PLACE? IF YES, WHAT KIND OF SURGERY? ……………………………………………………………

……

1. When did the patient consult you for the first time for the above problem? Provide exact date.

   ………

2. According to the patient's medical history has he/she mentioned that he/she has visited other doctors for the same problem? If yes, who and when? ………………………………………………………………………………

3. When were the first symptoms? If you don't know exactly state approximately ………………………………………

4. What are the results of X-Rays / biopsies / analyses? ……………………………………………………………………

   ………

5. In case of pregnancy when did it start? State exact date: …………………………………………………………………

WAS THERE A SURGERY WITH HOSPITALISATION? DATE OF SURGERY

☐ Yes ☐ No ………………………………………………

ONLY TREATMENT DATE OF ADMISSION DATE OF DISCHARGE

☐ Yes ☐ No …………………………… ……………………………

DETAILED ACCOUNT OF HOSPITAL OR CLINIC

I. DAYS IN HOSPITAL:

NUMBER ………. € …………. PER DAY

TOTAL: € ………….

II. SURGEON´S FEE: € ……………………………

III. HOSPITAL EXPENSES

A. SURGERY EXPENSES	€ …………………
B. ANESTHETIST´S FEES	€ …………………
C. IN-HOSPITAL X-RAYS	€ …………………
D. IN-HOSPITAL BLOOD TESTS	€ …………………
E. IN-HOSPITAL MEDICINES (State in detail the kinds and quantities of medicines)	€ …………………
TOTAL	€ …………………

TOTAL PAID EXPENSES €

……………………………………………………………………… ……………………………………

SIGNATURE & SEAL OF HOSPITAL OR CLINIC DATE

(NOTE: ATTACH RECEIPTS FOR PAID EXPENSES)