ASAN Medical Center
88, Olympic-ro 43-gil, Songpa-gu, Seoul 05505, Korea
http://eng.amc.seoul.kr

Physician's Statement *(Mandatory)* – To be completed by a physician

Your patient ___________ will begin clinical observation program shortly at Asan Medical Center in Seoul, Korea. In order to maintain a safe environment for our employees and for our patients, the following information is needed prior to their placement. Please complete this form in order to facilitate the administrative process for your patient.

If you have any questions regarding the information below, please contact Asan Medical International via email (intedu@amc.seoul.kr).

Patient Name: ______________

Hospital ID: ________________

1. Current Medical History

Is this patient currently having any of the following symptoms?

Fever	(Yes No)	Chilled Sensation	(Yes No)
Night Sweats	(Yes No)	Sputum	(Yes No)
Hemoptysis	(Yes No)	Weight Loss	(Yes No)
Cough	(Yes No)	Skin Lesions(rash, blister etc.)	(Yes No)

Others: _______________________

Does this patient have a chronic illness? (Yes No)

If yes, please specify:

Diagnosis: _________________ Diagnosis Date: _______________
Diagnosis: _________________ Diagnosis Date: _______________
Diagnosis: _________________ Diagnosis Date: _______________

Please list all the drug(s) this patient has been taking constantly (if any):

Drug Name (Ingredient): ________________ Taking Since: ___________ (date)
Drug Name (Ingredient): ________________ Taking Since: ___________ (date)
Drug Name (Ingredient): ________________ Taking Since: ___________ (date)

Is this patient allergic to any particular substance(s)? (Yes No)

If yes, please identify the substance(s): ________________

2. Past Medical History

Has this patient ever been treated for Tuberculosis? (Yes No)

If yes, please provide the initial and end dates of the treatment:

Start Date: ___________________ End Date: ________________

If this patient has any other past history of illness, please provide details:

Diagnosis: __________________ Recovery Date: _____________

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3. Consultation

Did you find any abnormal medical conditions, including disabilities, during your examinations of this patient? (Yes No)

If yes, please specify:

Abnormal finding: ______________________

Physician's opinion regarding this finding: _____________________

Abnormal finding: ______________________

Physician's opinion regarding this finding: _____________________

4. Test Results

1) Anti HBVAb titer: ______________________ Date: ___________________

A negative test result requires verification of three vaccinations on the ***Immunization Check-Up List* **

2) Chest X-ray within six months of the patient's visit to Asan Medical Center

Result: ___________________________

Date: ____________________________

5. Overall Comments

1) Does this patient have communicable disease(s)? (Yes No)

2) Does this patient have any health condition(s) that may interfere with his/her ability to work as a healthcare professional? (Yes No)

3) Have you had contact with an infectious disease patient within the last 3 weeks? (Yes No)

I certify that all the information I have given on this form is complete, truthful, and accurate.

Physician's Name: ______________________ Date: ___________________

Title: ________________________________

Signature: _____________________________

Address: ____