



**INSTRUCTIONS**

- 1) Please type or use BLOCK letters when completing this form.
- 2) Section A & B **MUST** be completed and signed by a Medical or Dental Practitioner.
- 3) Patient's personal particulars & Next-of-kin's particulars **MUST** be completed.
- 4) The patient is to **sign and mail to Singapore Medical Association, Tiong Bahru PO Box 643 S(911602)**
  - the completed form, duly signed by the doctor
  - Cheque, Money Order, Postal Order or Cashier's Order, made payable to "Singapore Medical Association". (Please do not send Cash.)
  - two recent NRIC sized photographs (colour or B&W)
- 5) The Medik Awaz card will normally be mailed to the patient within 4 to 6 weeks of application.
- 6) For enquiries, please call 6223 1264.

**PERSONAL PARTICULARS (to be completed by Patient)**

**PATIENT:**

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_ S ( )  
 NRIC No \_\_\_\_\_  
 Telephone \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_  
 Ethnic Group \_\_\_\_\_ Blood Group \_\_\_\_\_

**NEXT-OF-KIN (spouse, child, relatives, etc) :**

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_ S ( )  
 Telephone \_\_\_\_\_  
 Relationship \_\_\_\_\_

**SECTION A - DRUG ALLERGIES (to be completed by Doctor ONLY)**

The information entered in this section will be edited for inclusion on the identification card. Please fill in clearly and accurately. Please provide both Trade and Generic names of the drug(s).

Drugs Suspected (Specify trade name)	Daily Dose & Route	Date Begun	Date Stopped	Reason For Use
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Concurrent Medication (Drugs given at the same time but not responsible for the reaction):

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**DESCRIBE REACTION:**

	Yes	No
(a) Anaphylactic Shock	<input type="checkbox"/>	<input type="checkbox"/>
(b) Eyes Puffy	<input type="checkbox"/>	<input type="checkbox"/>
Lips-swollen	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of tongue	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing (Rhonchi)	<input type="checkbox"/>	<input type="checkbox"/>
Hypotension	<input type="checkbox"/>	<input type="checkbox"/>

(c) Skin - Rash:  Generalised  
 Localised Specify \_\_\_\_\_

Rash:  Urticaria  Non urticaria  
 Pruritus  Yes  No

Mucosa Lesions: Oral  Yes  No

(d) Other adverse reactions : Describe \_\_\_\_\_

(e) Onset:  Gradual  Sudden  Unknown  
Requires hospitalisation  Yes  No

Source of Information:  Observed by reporting doctor  
 Past event recounted by patient/relative  
 Past event reported by another doctor  
 Others (specify) \_\_\_\_\_

**SECTION B - MEDICAL CONDITIONS (to be completed by Doctor ONLY)**

(Eg. bleeding tendency/diabetes) or long term medications like steroids or anticoagulants. This information will be displayed on patient's card/amulet.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**DOCTOR'S DECLARATION**

The facts as stated are to my knowledge correct and I have no objection to my name and telephone number being included on the identification card.

Doctor's Full Name (Print): \_\_\_\_\_

Hospital/ Clinic: \_\_\_\_\_

Ward: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
Doctor's Signature / Stamp

Telephone: \_\_\_\_\_ MCR No. \_\_\_\_\_

\_\_\_\_\_  
Date:

**PATIENT'S DECLARATION**

I \*have/have not applied for MEDIK AWAS Card previously. (If yes, my File No. is \_\_\_\_\_ )

I agree to this record being place with the MEDIK AWAS Committee of the Singapore Medical Association and that they and/or their Agents and the members of its staff will not be responsible in any way whatsoever in the event of my sustaining any loss, damage or injury whatsoever by reason of their wrongful act, neglect or omission.

I enclose a \$ \_\_\_\_\_ cheque made payable to "Singapore Medical Association" for

- registration and identification card (\$15)
- an amulet, identification card and registration (\$20). Limited to 3 drug allergies only.
- renewal of identification card (\$10). (Eg. change of address, loss of card or addition of new information)

(All fees are inclusive of GST.)

Date: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

**PLEASE NOTE:** After reviewing the application, the physician or patient may be contacted for further clarification by one of the physicians in the Medik Awas Committee.

**For Official Use**

Receipt No. : \_\_\_\_\_ Receipt Date: \_\_\_\_\_ File No.: \_\_\_\_\_