醫藥警備 MEDIK AWAS

A Community Service Organised by the:

SINGAPORE MEDICAL ASSOCIATION
For Doctors, For Patients

MEDIK AWAS CARD FOR DRUG ALLERGIES/MEDICAL CONDITIONS

APPLICATION & REGISTRATION FORM

GST Reg. No. M0-0000156-C

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, 2985 Jalan Bukit Merah #02-02C SMF Building, Singapore 159457 or email (scanned documents)** to: **medik@sma.org.sg**
   - the completed form, duly signed by the doctor and patient
   - payment by PayNow or Bank Transfer (Please do not send Cash or Cheque)
   - two recent Passport sized photographs (Color or Black & White)
5. The Medik Awas card will 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 to Patient: _____

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	☐	☐
(b)	Eyes Puffy	☐	☐
	Lips-swollen	☐	☐
	Swelling of tongue	☐	☐
	Wheezing (Rhonchi)	☐	☐
	Hypotension	☐	☐

(c) Skin – Rash: ☐ Generalised
☐ Localised Specify: _____
Rash: ☐ Urticaria ☐ Non urticaria
☐ Pruritus ☐ Yes ☐ No
Mucosa Lesion: Oral ☐ Yes ☐ No

(d) Other adverse reactions : Describe _____

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

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 such as 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: _____

Telephone: _____ MCR No.: _____

_____
Doctor's Signature / Stamp
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 paid $ _____ via ☐ #**PAYNOW (UEN No. S61SS0168E),** ☐ #**BANK TRANSFER SMA DBS Account No: 001-063564-6** for
☐ registration and identification card ($30)
☐ registration, identification card and amulet ($40). Limited to 3 drug allergies only.
☐ renewal of identification card or amulet ($15). Eg. change of address, loss of item or addition of new information)
(All fees are inclusive of GST)

#***Please indicate your full name as in NRIC as your reference so we can trace your payment and attach the payment screenshot.***

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.: _____