SHIP MASTER'S MEDICAL REPORT FORM

(When completed, the contents of this form shall be kept confidential and shall only be used to facilitate the treatment of the patient)

Date of report _____

Ship's identity and navigation status

Vessel Name:

Owner:

Name & address of on-shore agent:

Position (latitude, longitude) at onset of illness:

Destination and ETA (expected time of arrival):

The patient and the medical problem

Surname and first name:

Sex: Male ☐ Female ☐

Date of birth (dd/mm/yy): Nationality:

Seafarer registration number:

Shipboard job title:

Hour and date when taken off work: Hour and date when returned to work:

Injury or illness

Hour and date of injury or onset of illness:

Hour and date of first examination or treatment:

Location on ship where injury occurred:

Circumstances of injury:

Symptoms:

Findings of physical examination:

Overall clinical impression before treatment:

Treatment given on board:

Overall clinical impression after treatment:

Masters signature:

Isle of Man Ship Registry

Telemedical consultation

Hour and date of initial contact

Mode of communication (radio, telephone, fax, other)

Surname and first name of telemedical consultant

Details of telemedical advice given

To the Examining Doctor

Please see this patient and complete this section of the form. Return original to ships Master (or agent)

Diagnosis

Treatment (Please specify exactly all medicines to be taken including the generic name of the medicine, the required dose, frequency of the dose, the manner in which it should be taken and any other treatments required)

Should patient see another doctor? ☐ No ☐ Yes When?

Contagious or infectious disease? ☐ No ☐ Yes Are any precautions necessary for other crew members?

Estimated duration of illness (days)

Fit for work now ☐

Fit for work from ☐ Date:

Fit for restrictive work ☐ What restrictions?

Unfit for work ☐ For how many days?

Bed rest necessary ☐ For how many days?

Recommended to be signed off ☐

- and be repatriated ☐ Is air transport recommended?
- and go to hospital ☐

The patient was seen on (date) Charge

Payment received ☐ Yes ☐ No

- in the doctors office ☐
- on board ☐
- Elsewhere ☐ Please specify

Doctors name, address and telephone number

Doctors signature:

N.B. Attach all relevant medical reports to this form