When completed, the contents of this form, and any attachments, shall be kept confidential and only be used to facilitate medical treatment for the seafarer.

The original should accompany the seafarer for treatment ashore (including in the event of a MEDIVAC) and be returned to the vessel after treatment.

**PART A – SEAFARER AND ON BOARD TREATMENT INFORMATION**

**Vessel and Location details**

|  |  |
| --- | --- |
|  Vessel: |  |
|  Type of vessel: |  |
|  IMO Number:  |  | Cargo: |  |
|  Vessel Owner: |  |
|  Location (Lat/Long or Port) at  onset of illness or injury: |  |
|  Next port: |  |  ETA (Date): |  |
|  Local agent Name: |  |
|  Contact details (Phone, email): |

**Seafarer (Patient) details**

|  |  |
| --- | --- |
|  Full name: |  |
|  Date of Birth: |  | [ ]  Male[ ]  Female  |
|  Nationality: |  |  Spoken Language: |  |
|  Identity document number: | [ ]  Passport [ ]  Seafarers identity document |
|  Position/Rank:  |

|  |  |
| --- | --- |
|  Date and time off work:        |  Return to work (if applicable):       |

|  |  |
| --- | --- |
|  Known medical conditions/allergies/routine medications:  |  |

**Details of the injury or illness**

|  |
| --- |
|  Date and time of injury or onset of illness: |
|  Location on vessel where injury/illness occurred: |
|  Circumstances of injury/illness: |
|  Date and time of first examination on board: |
|  Symptoms:  |
|  Findings of on board examination: |
|  Treatment administered on board: |
|  Condition of patient after treatment: |

Shore treatment required: Yes [ ]  No [ ]

MEDEVAC required: Yes [ ]  No [ ]

|  |
| --- |
|  MEDEVAC Undertaken: |

**Tele-Medical Advice (if required)**

|  |  |
| --- | --- |
|  Date and time of first contact with medical advisor: |  Name of medical advisor: |
|  |
|  Medical advice and instruction received:  |
|   |
| Master’s Full Name:  |  | Master’s Signature: |  | Date: / / |

**PART B – ON SHORE TREATMENT AND FITNESS FOR DUTY**

**For use by the examining Medical Practitioner (or Health care professional)** After examining the patient, please complete Part B of this form and return to the Master (or local agent) complete with any relevant medical reports or documentation.

Diagnosis:

|  |
| --- |
|  |

Treatment or medication administered:

|  |
| --- |
|  |

Further treatment or medication required:

|  |
| --- |
|  |

Further medical visit required: Yes [ ]  No [ ]

|  |  |
| --- | --- |
| Suggested date for next examination: |  |

|  |  |
| --- | --- |
| Estimated duration of illness or incapacity (days): |  |

**To be completed if the patient is FIT FOR WORK**

Fit for work now: [ ]

Fit for work from: [ ]  Date  / /

Fit for work with restrictions: [ ]

Details of any restrictions on work:

|  |
| --- |
|  |

**To be completed if the patient is UNFIT FOR WORK**

Unfit for work now: [ ]  Estimated duration (days):

Bed rest required: [ ]  Estimated duration (days):

The patient should leave the vessel: [ ]  and be:

Admitted to Hospital [ ]  Repatriated [ ]

Patient may travel by air: [ ]

Unaccompanied [ ]  Only with medical escort [ ]

Medical treatment required at final destination:

|  |
| --- |
|  |

**Declaration by medical practitioner:**

|  |  |
| --- | --- |
| Place of medical examination:  | Date of medical examination:  / / |

Charge for examination:  Payment received: Yes [ ]  No [ ]

|  |
| --- |
|  Full name, address and telephone of medical practitioner: |

|  |  |  |
| --- | --- | --- |
| **Medical Practitioner’s Signature** |  | **Medical Practitioner’s Stamp** |
|  |