

Date: _____

NTUC INCOME INSURANCE CO-OPERATIVE LTD
Examination Service Fax Order Form
PRIVATE AND CONFIDENTIAL

To: **MEDIFAST (S) PTE LTD**

Tel: 6222 3373

Fax: 6222 0090

Mobile Services

In-Clinic Services

PART 1: AGENT'S PARTICULARS

Full Name of Agent: _____ Rep. Code: _____

Office Phone: _____ Mobile Phone: _____

Branch: _____

Agent's Instruction: Medifast to contact examinee for appointment and other necessary arrangements. Yes / No

PART 2: EXAMINEE'S PARTICULARS

Proposal / Policy Number(s): _____

Full Name: _____ Sex: Male / Female
Surname (Underline)

Date of Birth: _____ / _____ / _____ NRIC / PASSPORT: _____
Day Month Year

Contact Number (Office) : _____ (Home): _____ (Others): _____

Preferred Examination Date & Time: _____ / _____ / _____ _____ Time _____ / _____ / _____ _____ Time
Day Month Year

Examination Address: **(Please tick where appropriate)**

(Mobile Services Only) _____

Nearest Intersection / MRT Station: _____

TAKE NOTE: A surcharge of \$15 will be imposed for areas not accessible by MRT or buses.
A surcharge of \$10 will be imposed for areas accessible by private shuttle service (with scheduled time).

MediFast Medical Centre
Novena Medical Centre, No. 10 Sinaran Drive, #11-27, 28 & 29, Singapore 307506

PART 3: TYPE OF SERVICES REQUIRED PLEASE ATTACH UNDERWRITER'S MEMORANDUM

Required by (Dept): Insurance Advisor Life Insurance Dept Others (Please specify): _____

Medical Examination Resting ECG 3 Blood Pressure Reading

Urine FEME (Micro urinalysis) **Female client: test to be taken after 5 – 7 days of menstruation**

Blood test(s) (Please tick specific blood test(s) required):

Liver Function Test	<input type="checkbox"/>	Complete Blood Profile *	<input type="checkbox"/>	Thyroid Function Test	<input type="checkbox"/>
Lipids Profile *	<input type="checkbox"/>	Renal Function Test	<input type="checkbox"/>	Diabetic Diagnostic Test	<input type="checkbox"/>
Full Blood Count *	<input type="checkbox"/>	HIV **	<input type="checkbox"/>	Other:	<input type="checkbox"/>

TAKE NOTE: * EXAMINEE MUST FAST FOR AT LEAST 8 HOURS. PLAIN WATER IS ALLOWED
** HIV TEST: HIV CONSENT FORM TO BE SIGNED BY THE EXAMINEE

SPECIAL INSTRUCTIONS (if any): _____ overweight / fine vein / phobia of blood taking

Signature of Agent / Agency Secretary _____ Date: _____