REPORT OF MEDICAL INJURY

Hospital or Medical Centre: ST THOMAS’ HOSPITAL

Address: Westminster Bridge Rd, Lambeth, London SE1 7EH

Date:

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| NAME: | SURNAME: |
| PASSPORT NO.: | NATIONALITY: |
| ADDRESS: |
| POSTCODE: | CONTACT NUMBER: |
| GENDER: | CIVIL STATUS: |
| DATE OF BIRTH: | AGE: |

Name of examining doctor:

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| Symptoms:  |
| Medical examination: |
| Recommendations: |