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: |