

<b>Policy Title:</b> MOH Medical Report Standard Guide Issuance Policy.	
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## 1. Introduction:

1.1 Physicians often receive requests from their patients for a medical letter, form or report to prove to the patient's employer, institution or insurer a valid reason for taking time away from work or school or to obtain disability benefits or a pension. Patients may also require a treating physician's report to seek compensation for physical and/or psychological injury. In accordance with Law No. 70 of 2020 regarding the practice of the medical profession, its supporting professions and the ministry of health code of ethics, physicians have an ethical and legal obligation to provide a timely, factual report on patients they have cared for, even if they have not recently seen or examined these patients and cannot provide an updated report. As such, establishing a standard for medical reporting and an organizational policy to the issuance of reports is necessary to ensure health care providers, and the respective supportive administrative staff (e.g. medical records, archivists etc.) provide patients with the medical reports requested in an efficient manner in accordance with the above and related laws.

## 2. Purpose:

2.1 The purpose of this policy is to establish a standard for medical reporting and an organizational policy for the issuance of reports, in an efficient manner, by health care providers, and the respective supportive administrative staff (e.g. medical records, archivists etc.) in accordance with the above and related laws.

## 3. Policy Statements:

3.1 This policy is concerned with medical reports issued by physicians from health care facilities for patients (inpatient or outpatients) regarding their medical condition, treatment plans or good status.

3.2 Special medical reports regarding incapacity, injuries, mental health and competence are regulated and issued by decrees and designated sites (medical councils, occupational medicine and committees from the MOH or the public institution for social security or the Kuwait center for mental health respectively).

- 3.3** It is important to remember that patients, employers and insurers will be relying on the objective information provided to them in such reports, to make decisions for the patient that may include benefits, adjusted workplace environments and sick leave, etc.
- 3.4** Misinformation, or erroneous or unfounded opinions should be avoided as employers and insurers who have relied on such representations may commence legal action for damages against the author.
- 3.5** It may be considered professional misconduct to provide untruthful information or information beyond the scope of the patient's consent, or the inappropriate delay in producing medical certificates.
- 3.6** Reports should aim to be **FAST**: **F**actual, **A**uthorized, **S**olid and **T**imely.

#### 4. Definitions:

- 4.1 Authorship:** Is attributed to a specific individual or entity acting at a particular time. Authors are responsible for the completeness and accuracy of their entries in the health record.
- 4.2 MOH:** Ministry Of Health.
- 4.3 HCF:** Health Care Facility.

#### 5 Tenets Of Medical Letters, Forms, And Reports:

##### 5.1 Purpose of the Report:

- 5.1.1** The purpose of the report should be stated by the requesting entity or legal guardian (verbally and by an official request as set by the MOH leadership, decrees and laws per purpose).
- 5.1.2** Requests for a treating physician letter or report are either made in person, by electronic request or telecommunication as set by the MOH health care facility or leadership circulars, policies or decrees.
- 5.1.3** The purpose of the report should be stated on the letter head of the report accordingly (e.g. sick leave, medical report, or any other purpose of report set by the MOH leadership).
- 5.1.4** All requests for medico-legal reports (e.g. Authority of Medical Responsibility, presiding judge, a patient's lawyer requests of a summary of their condition) are typically made in writing, stating the purpose of the report, to the MOH health care facility director in accordance with Law No. 70 of 2020 regarding the practice of the medical profession, its supporting professions, article 28, (either directly or through the MOH respective legal, professional or administrative leadership).

##### 5.2 Factual:

- 5.2.1** The aim of a treating physician's report is to provide facts, not opinions. (Opinions are typically provided as part of independent medical examinations or in expert reports).
- 5.2.2** The report should respond only to the specific questions asked without speculation on what lawyers, employers or others need.
- 5.2.3** The report should provide only factual information within the author's expertise, without bias or conflict of interest.
- 5.2.4** In accordance with the MOH decree 83/2015, medical reports regarding psychiatric patients pertaining to patient competency or any legal matter are to be referred to and issued by Kuwait Center for Mental Health.

### 5.3 Authorized (Consent):

**5.3.1** The answers you provide should be supported by the medical record but should contain only information the patient authorized to be released. If the patient has placed restrictions on what they have authorized you to cover, indicate areas where restricted information is relevant to your response and/or results in an incomplete response. Discuss with the patient that you may have to note the restrictions in your response.

**5.3.2** Authority to request a medical report:

The authority to request a medical report lies with the following:

- The patient him/herself.
- Legal guardianship with the official legal letters stating guardianship.
- Familial guardian for patients under the age of 18 years.
- Custodians of patients by court rule.
- Any mentally competent consenting person designated by a mentally competent patient to represent the patient him/herself during care and/or admission to a HCF by official consent on the designated form (in accordance with article 29 of the law 70 for the year 2020).

**5.3.3** Requests for a letter, form, or report can come from many different sources including the patient or a substitute decision-maker, the legal guardian of a child or an incapable adult, or from a third party such as a lawyer, insurance company, or government agency. Documentation by the reporting physician/health care practitioner or the designated request recipient medical report issuing entity (e.g. medical records department) that a note was provided should be ensured and a copy of it kept in the medical record in accordance with Law No. 70 of 2020 regarding the practice of the medical profession and its supporting professions.

**5.3.4** Written authorization and requests should state:

**5.3.4.1** To whom the report is to be sent.

**5.3.4.2** The time period the report should cover.

**5.3.4.3** The subject matter to be addressed.

**5.3.4.4** When the report is required.

**5.3.4.5** Only content authorized by the patient, legal guardian or requesting court should be released.

**5.3.4.6** If a request for a medical report is requested by official state authorities and entities (e.g. as the Ministry Of Health, Authority for Medical Responsibility, Judge of court) the above patient rights of restriction of information or access to his/her medical records is waived to the state and its representative authorities in accordance with Law No. 70 of 2020 regarding the practice of the medical profession and its supporting professions, article 45 and 49.

### 5.4 Solid:

**5.4.1** A report should be based on facts and be sound.

**5.4.2** Before a letter or form is completed, review of the medical record is paramount to base the report on that information avoiding any speculation.

**5.4.3** If patients ask for a letter about their state of health at a time when they were not personally assessed by the author with requests to make statements that the author cannot corroborate. The author may elect to write, "The patient reports that....." with documentation clarifying the patient was not assessed in real time.

**5.4.4** If the report, based on the facts in the record, does not align with the patient's expectations, the author's professional obligation to be factual and objective

should be explained to the patient or requestor. This discussion should be documented in the medical record.

**5.4.5** Health or any information about another identifiable person, should generally be redacted.

**5.5 Timely:**

**5.5.1** Medical letters, forms and reports should be provided in a reasonable time period.

**5.5.2** Timelines will be set by the MOH or designated facility leadership.

**5.5.3** Inability to comply with the timeline necessitates contact of the requester to alert them to the reasons for a potential delay.

**5.5.4** The MOH health care facility and/or leadership will designate the responsibility of contacting the requester to alert them to the reasons for a potential delay as seen fit through organizing circulars, policies or decrees.

**5.6 Providing supporting medical records:**

**5.6.1** If a request for a medical report is requested by official state authorities and entities (e.g. as the Ministry Of Health, Authority for Medical Responsibility, Judge of court) the above patient rights of restriction of information or access to his/her medical records is waived to the state and its representative authorities in accordance with Law No. 70 of 2020 regarding the practice of the medical profession, its supporting professions, article 45 and 49.

**5.6.2** Health information about another identifiable person, should generally be redacted.

**6 Components Of A Medical Report:**

**6.1** In accordance with Law No. 70 of 2020 regarding the practice of the medical profession, its supporting professions, article 22, a medical report should be composed of **the following:**

**6.1.1** Name of the patient and relevant demographics (age, gender, civil ID and medical record number).

**6.1.2** Title/purpose of the medical document (e.g. medical report, sick leave, attestation of fitness etc.) and the relevant medical information regarding the respective patient and the requested purpose of the report.

**6.1.3** Name of the reporter/author (health care practitioner).

**6.1.4** Profession, specialty and rank of the reporter/author.

**6.1.5** The department and facility from which the reporter/author issued the report.

**6.1.6** The date and time the report was issued.

**6.1.7** Signature of the reporter/author.

**6.1.8** The attesting signatures of the respective author's department chair and/or health care facility director depending on the MOH leadership rules, regulations and decrees.

**7 Process of Requesting a medical report:**

**7.1** The MOH health care facilities (or MOH leadership) are to delegate to the department of medical records to designate medical report services/office through which medical report requests, verification and issuance is provided to the patients, legal guardians or requesting entities.

- 7.2** The medical report services/office is to accept formal requests for medical reports by the following:
- 7.2.1** The patient him/herself (with a verified civil ID or credentials with civil ID numbers).
  - 7.2.2** Legal guardianship with the official legal letters stating guardianship.
  - 7.2.3** Familial guardian/next of kin (father/mother/brother/sister/son/daughter) for patients under the age of 18 years (with a verified civil ID or credentials with civil ID numbers and credentials proving kinship).
  - 7.2.4** Custodians of patients by court rule.
  - 7.2.5** Any mentally competent consenting person designated by a mentally competent patient to represent the patient him/herself during care and/or admission to a HCF by official consent on the designated form (in accordance with article 29 of the law 70 for the year 2020).
- 7.3** All the above should submit the patient's civil ID for verification and the evidence of kinship, guardianship, power of attorney, waiver or designation on request of the report.
- 7.3.1** The civil ID of the patient and the applicant should be scanned and attached to the request.
  - 7.3.2** A copy of the civil ID of the patient, the applicant and the request of the report (in addition to any evidence of kinship, guardianship, power of attorney, waiver or designation) should be saved by the medical records.
- 7.4** The applicant must complete the medical report request form at the medical report office (or MOH designated portal if available).
- 7.5** Paper medical report request forms should consists of **3 copies**:
- 7.5.1** The first copy (white): for the medical file and/or for the physician writing the report.
  - 7.5.2** The second copy (blue): for the applicant of the medical report request (e.g. patient, legal guardian).
  - 7.5.3** The third copy (yellow): for the medical report office employee to save and archive the request at the office.
  - 7.5.4** For paperless/electronically issued request forms, a copy should be saved in the respective patient's file and applicant's requesting portal or app.
- 7.6** For completion of the medical report request the following must be included:
- 7.6.1** Patient name.
  - 7.6.2** Civil ID number.
  - 7.6.3** Inpatient or outpatient.
  - 7.6.4** Reason for report (including directed to whom).
  - 7.6.5** Applicant details (if not the patient him/herself, e.g. copy of power of attorney or custody etc.).
  - 7.6.6** Treating department, unit, (ward if inpatient) and physician.
- 7.7** If the patient has not been seen for a period of more than 6 months, the employee transfers him/her to the outpatient clinic unit to make an appointment with the respective physician, or treating team, for review and reassessment, after which the medical report may be requested.
- 7.8** If the patient has not been seen at the outpatient clinic for more than one year, he/she should be referred back to their catchment area primary health care center (PHC) to

be assessed, then referred to the respective health care facility outpatient clinic for review and reassessment, after which the medical report may be requested.

- 7.9** The medical report office will ensure saving a copy of all medical reports issued in the respective patient's file, as per article 22 of the law #70 for the year 2020.
- 7.10** For patients who were admitted to the hospital at any time or during the request of the report, the medical report office employee will communicate with the head of the unit to find out the name of the treating physician or his representative to write the report for the patient **accordingly**:
- 7.10.1** at times, and for some subspecialty units (e.g. hematology – neurology - gastroenterology / hepatology - nephrology - endocrinology – urology - rheumatology - respiratory) requests are sent directly to the department leadership to coordinate and delegate their respective physicians to write the reports.
- 7.10.2** After the physician completes the medical report, it is submitted for approval by the head of the unit and thereafter, the hospital director.
- 7.11** The medical report office will ensure informing the applicant how to receive the medical report electronically, by website of Ministry of Health ([www.moh.gov.kw](http://www.moh.gov.kw)) or by application (q8seha with verification and authentication with Kuwait ID application) or paper form.
- 7.12** The employee in the medical report office is responsible for following on the status and progress of medical report requests, following up on submissions, approvals, delays in reports and technical issues with the respective physicians/authors.
- 7.13** Chairs of clinical departments and supportive services responsible for issuing medical reports should ensure members of their departments adhere to the standard policy set above.
- 7.14** The department of medical records and the designated medical report services/office are to regularly review and audit adherence to the above set standards and time of report issuance with regular communication and feedback with the respective departments regarding performance, efficiency and adherence to the policy set above.

## 8 References:

- ✓ Law No. 70 of 2020 regarding the practice of the medical profession, its supporting professions.
- ✓ MOH decree 83/2015.
- ✓ Canadian Medical Protective Association; Medical letters, forms, and reports. May 2022.
- ✓ General Medical Council, UK official site.