

ATTENDING PHYSICIAN'S STATEMENT

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To be completed by the attending physician at the Insured Person's expense.

Name of Patient	Passport/Identity Card No.	
What is the diagnosis and when was it diagnosed?	<input type="text"/> <input type="checkbox"/> Injury <input type="checkbox"/> Sickness	
Was the patient referred to you by a general practitioner?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate his/her name and address. <input type="text"/>	
Of what symptoms did the patient complain? When did patient first consult you for this condition?	<input type="text"/>	
To the best of your knowledge, has the patient ever had the same or similar condition(s) or symptom(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state dates and conditions / symptoms: <input type="text"/>	
Was the condition caused by any underlying disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify: <input type="text"/>	
According to the patient, how long had he/she been experiencing these symptoms?	How long do you feel the symptoms had lasted?	<input type="text"/>
Had the patient previously seen any other doctor on account of these symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide name & address of doctor treating the patient. <input type="text"/>	
Is this a prearranged consultation or admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state the name & address of the referring doctor. <input type="text"/>	
Did you inform the patient of your diagnosis and has any treatment been recommended?	<input type="checkbox"/> Yes <input type="checkbox"/> No If so, When did you do so? <input type="text"/>	
Is the diagnosis due to or associated with any of the following?	Congenital anomalies? <input type="checkbox"/> Yes <input type="checkbox"/> No	Heredity conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Drugs or alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	Refractive error or correction of eyesights? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Cosmetic or plastic surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	Routine medical check-up? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Mental or nervous disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No	General health screen? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Suicide or attempted suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No	HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Pregnancy or child birth? <input type="checkbox"/> Yes <input type="checkbox"/> No	Self-inflicted injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
Did injury or sickness require	Hospitalisation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Admitted <input type="text"/>
		Date Discharged <input type="text"/>
	X-rays? <input type="checkbox"/> Yes <input type="checkbox"/> No	Special diagnostic procedures? <input type="checkbox"/> Yes <input type="checkbox"/> No
Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If the patient had a surgical procedure, please fill in the boxes below		
Name and nature of procedure	Date of the operation	<input type="text"/>
In the case of injury, were the patient's complaints solely caused by this current accident? If not, is there any connection with a previous accident or any other causes? Please specify.		
Brief discharge summary (including treatments, investigation procedures, results, and /or any complications and follow-up plan)		
Is the patient taking any medication relevant to the above condition? If yes, please specify the medications and when was he first prescribed with it.		

Is the patient undergoing any test or waiting for result of any test? If yes, please specify the tests.									
Was patient given a terminal diagnosis? If yes, please state the date when patient was notified of his/her terminal diagnosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
Is the patient still under your care for this condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
Bearing in mind the patient's occupation, do you feel that the injuries or sickness would have prevented him from working?									
How long was, or will the patient be continuously totally disabled (unable to work)									
How long was, or will the patient be partially disabled?									
Give details of any circumstances, such as intoxication, physical defects or medical history which may have contributed to the accident or sickness and/or lengthen the period of disability.									
Whether injuries sustained will result in any permanent disablement/incapacity. If so, please advise extent of disablement/incapacity.									

DECLARATION AND AUTHORISATION

I hereby certify that I have personally examined and treated the patient for the above *injuries/sickness and that the facts as given above represent my opinion of *his/her condition.											
Name of Physician		Tel no.									
Address											
Signature		Dated	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y				
Company Stamp		Qualification									

*delete as applicable

NB: No claim can be admitted unless medical certificate from a duly qualified and registered medical practitioner on the form above is furnished at the expense of the Insured,



Bring on tomorrow

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