Personal Accident Claim - Doctor's Statement

SECTION 2 – DOCTOR'S STATEMENT (to be completed by the attending Doctor at claimant's expense)

A) Patient's Particulars	
Name of Patient	Gender
NRIC/FIN or Passport No.	Date of Birth (ddmmyyyy)

B) Patient's Medical Records

1) Please state over what period does the Hospital / Clinic's record extend?

(i) Date of First Consultation (ddmmyyyy)

(ii) Date of Last Consultation (ddmmyyyy)

(iii) No. of consultations during the above period:

(iv) Name of hospital/clinic and Reasons of consultations (with dates):

2) Are you the patient usual medical doctor? ❒ Yes ❒ No

If "Yes", since when? (ddmmyyyy)

If "No", please provide name and address of the patient's regular doctor.

3) Was the patient referred to you? ❒ Yes ❒ No

If "Yes", please provide:

(i) Date referred (ddmmyyyy)

(ii) Reason the patient was referred:

(iii) Name and address of doctor recommending the referral:

If "No", how did the patient come to consult at your hospital/clinic? (e.g. A&E)

4) Have you referred the patient to any other doctor? ❒ Yes ❒ No

(i) Date referred (ddmmyyyy)

(ii) Reason for referral:

(iii) Name and address of doctor referred to:

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5) Does the patient have or ever have had any significant health conditions, medical history or any illness (e.g. bodily impairments or disability, hepatitis, diabetes, hypertension, hyperlipidaemia, etc.) If "Yes", please provide: ❒ Yes ❒ No

Details of symptoms	Exact Diagnosis	Date Diagnosed	Treatment

6) Name and address of doctor whom the patient consulted for the condition(s) stated in Question 5 above.

7) What is your source of the above information?

8) Please give details of the patient's habits in relation to past and present **smoking**, including the duration of smoking habits, number of cigarettes smoked per day and source of this information:

No. of Years of smoking	No. of sticks per day	Source of information

9) Please give details of the patient's habits in relation to **alcohol consumption**, including the amount of the alcohol consumption, frequency and the source of this information.

Type of Alcohol	Quantity per Consumption	Frequency (per week / month, etc)	Source of information

C) Details of Illness / Accident

1) Is the condition due to an Illness or an Accident? Please tick **(√)** box ❒ Illness ❒ Accident

2) (i) Date of Accident (ddmmyyyy)

(ii) Please describe how the accident occurred.

(iii) Please describe the extent and severity of injury sustained, including the anatomical site involved.

3) Please provide details of the current condition:

(i) Date of First consultation for the current condition (ddmmyyyy)

(ii) Details of symptom(s) presented during the First consultation.

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C) Details of Illness / Accident (continue)

4) Were the injuries caused solely by the accident mentioned in question (2) above? ❒ Yes ❒ No

5) What is the underlying cause of illness/injury?

6) Were there any underlying illnesses/ conditions that attributed to the accident/injury? ❒ Yes ❒ No
If "Yes", please provide full details of the condition and how it attributed to the accident/injury.

7) (i) Exact Diagnosis:

(ii) ICD-10 Code (if applicable):

(iii) Date of Diagnosis (ddmmyyyy) | | | | | | | | |

8) Name and address of hospital/clinic at which the patient was treated and/or admitted.

9) Date and time of admission (ddmmyyyy) | | | | | | | | | a.m. / p.m.

10) Date and time of discharge (ddmmyyyy) | | | | | | | | | a.m. / p.m.

11) Were surgical procedures performed on the patient? ❒ Yes ❒ No
If "Yes", please describe in details the surgical operation(s) performed.

Please attach copy of the Operation Reports.

12) Please state the objective(s) of the operation(s).

13) If two (2) or more of the surgical procedures were performed, were they performed under the same anaesthesia? If "No", please give details. ❒ Yes ❒ No

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C) Details of Illness / Accident (continue)

14) Please state the Dates of surgery (ddmmyyyy) and attach copy of operation Reports.

15) Is patient still under your care for this condition? ❒ Yes ❒ No

If "No", please state Date of Last consultation (ddmmyyyy)

16) If no surgery was performed, was surgery advised? ❒ Yes ❒ No

If "Yes", please give reasons why patient did not proceed with the surgery.

17) Please provide the period of medical leave given to patient.

(a) **Temporary Total Disability** (ddmmyyyy)
- Totally and continuously disabled on a temporary basis and prevented from performing <u>each and every duty</u> pertaining to the patient's condition

From:

To:

(b) **Temporary Partial Disability** (ddmmyyyy)
- Partially and continuously disabled on a temporary basis and prevented from performing <u>one or more duties</u> pertaining to the patient's condition

From:

To:

18) When is the patient expected to recover? (ddmmyyyy)

19) If recovery is not reasonably expected, is the disability total and permanent, and having no hope of improvement. If "Yes", please provide the basis of your evaluation ❒ Yes ❒ No

20) Is the disability "total and permanent", ***<u>and</u>*** such that the patient is entirely prevented from engaging in or giving attention to any and every kind of work to earn or obtain wages, compensation or profit for the remainder of his/her life? ❒ Yes ❒ No

If "Yes", when did such disability commence? (ddmmyyyy)

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C) Details of Illness / Accident (continue)

If patient has **no** occupation at time of accident:

21) Based on your most recent records, please **circle** as applicable in relation to the patient's ability to perform the Activities of Daily Living (ADLs), **whether aided or unaided** by special equipment, device and/or apparatus (and not pertaining to human aid).

Definition of ADL	Extent of Independence	Yes / No	If patient always requires another person's help, please state: (a) Reasons, and (b) For how long has he/she been continuously unable to do so?
Washing/Bathing: The ability to wash in the bath or shower (including getting into and out of the bath and shower) or wash satisfactorily by other means	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment • Always require another person's assistance throughout the entire activity	**Yes / No** **Yes / No** **Yes / No**	
Dressing: The ability to put on, takes off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment • Always require another person's assistance throughout the entire activity	**Yes / No** **Yes / No** **Yes / No**	
Transferring: The ability to move from a bed to an upright chair or wheelchair and vice versa.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment • Always require another person's assistance throughout the entire activity	**Yes / No** **Yes / No** **Yes / No**	
Mobility: The ability to move indoors from room to room on level surfaces.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment • Always require another person's assistance throughout the entire activity	**Yes / No** **Yes / No** **Yes / No**	
Toileting: The ability to use the lavatory or otherwise managed bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment • Always require another person's assistance throughout the entire activity	**Yes / No** **Yes / No** **Yes / No**	
Feeding: The ability to feed oneself once food has been prepared and made available.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment. • Always require another person's assistance throughout the entire activity	**Yes / No** **Yes / No** **Yes / No**	

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C) Details of Illness / Accident (continue)

22) Did the patient sustain **permanent and total loss or total loss of use of limb**? ❒ Yes ❒ No

(Loss refers to complete, irrecoverable and permanent loss of use or loss by complete physical severance)

If "Yes", please provide the following details and support with hospital reports.

(a) Please describe in details the affected organ or limb.

(b) For loss related to finger or toe, please specify the affected phalanx/phalanges and on which finger/toe.

23) Did the patient suffer from **major burns**? ❒ Yes ❒ No

If "Yes", please state the areas affected on the patient's body, the percentage of surface area, and the degree of burns in each affected area and support with hospital reports such as Burns report.

24) Did the patient suffer from **permanent and incurable insanity** where he/she is to be institutionalized in a mental home or institution? ❒ Yes ❒ No

If "Yes", please provide the following details.

(a) Name and address of psychiatrist who recommended the admission.

(b) Date of recommendation (ddmmyyyy)								
(c) Date of admission (ddmmyyyy)								
(d) Date of discharge (ddmmyyyy)								

25) Did the patient sustain **Total and permanent loss of teeth**? ❒ Yes ❒ No

Teeth refers to sound and natural permanent teeth only.

If "Yes", please state the number of teeth affected and support with any hospital & x-ray reports.

26) Did the patient undergo **surgical operation to remove the lower jaw**? ❒ Yes ❒ No

If "Yes", please support with any hospital & operation reports.

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C) Details of Illness / Accident (continue)

27) **Female only**,

Did the patient suffer from a **miscarriage**? ❒ Yes ❒ No

If "Yes", please provide the following details and support with any hospital & operation reports.

(a) Date of miscarriage (ddmmyyyy)

(b) How many weeks was the patient pregnant prior to the accident?

28) Did the patient sustain any **fracture of the bone**? ❒ Yes ❒ No

If "Yes", please provide the following details and support with any hospital & x-ray reports.

(a) Please describe in details the exact location of the fractured bone(s).

(b) Is the injury an Open or Closed Fracture? Please tick **(√)** box. ❒ Open Fracture ❒ Closed Fracture

(c) Please state the number of bone(s) fractured.

29) Did the patient sustain any **dislocation of the bone**? ❒ Yes ❒ No

If "Yes", please provide the following details and support with any hospital & x-ray reports.

(a) Please describe in details the exact location of the dislocated bone(s).

(b) Was the dislocated bone(s) required surgery under anaesthesia? ❒ Yes ❒ No

30) Was the patient referred to a physiotherapist for further management? ❒ Yes ❒ No

If "Yes", please provide the name and address of the physiotherapist.

31) What is the prognosis of patient's condition? Please provide details on the basis of your evaluation.

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C) Details of Illness / Accident (continue)		
32) Is the patient's condition associated with the following:		
(i) The influence of alcohol? If "Yes", please state blood alcohol content and quantity consumed.	❒ Yes	❒ No
(ii) The influence of drug? If "Yes", please state drug type and quantity consumed.	❒ Yes	❒ No
(iii) The influence of the taking of poison or inhalation of gas?	❒ Yes	❒ No
(iv) Any condition resulting from childbirth, pregnancy and complications thereof?	❒ Yes	❒ No
(v) Bodily infirmity, mental, psychiatric, anxiety, nervous disorders, sleep disturbance disorders and functional disorders?	❒ Yes	❒ No
(vi) Birth defects, including hereditary conditions or congenital anomalies	❒ Yes	❒ No
(vii) Any form of dental care or surgery?	❒ Yes	❒ No
(viii) Any treatment for obesity, weight management program?	❒ Yes	❒ No
(ix) Treatment for infertility, contraception, sterilisation, impotence, sexual dysfunction or assisted conception tests or sex change operations	❒ Yes	❒ No
(x) Any elective surgery, cosmetic or plastic surgery not necessitated by injury or illness?	❒ Yes	❒ No
(xi) Human Immunodeficiency Virus infection, AIDS or any sexually transmitted disease?	❒ Yes	❒ No
(xii) Alcohol, drug abuse or the use of unprescribed drugs where such drugs are required by law to be prescribed by a registered doctor?	❒ Yes	❒ No
(xiii) Self-inflicted injury – e.g. suicide, attempted suicide	❒ Yes	❒ No
(xiv) Participating in hazardous activity (e.g. aerial activity, rock climbing, mountaineering, underwater activities, bungee-jumping, martial arts activities, boxing, etc).	❒ Yes	❒ No
(xv) Participation as a professional in competitive sports	❒ Yes	❒ No
(xvi) Committing, attempting or provoking an assault or a felony or any violation of the law	❒ Yes	❒ No
33) If any of the conditions listed in Question 32 (i) to (xvi) above is "Yes", please provide details.		

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C) Details of Illness / Accident (continue)
34) Please provide us with any other additional information that will enable the Company to assess this claim.
35) Please enclose copies of all reports including x-rays, CT scans, surgical reports, laboratory test results, physiotherapist, inpatient discharge summary and any relevant hospital reports that are available.

D) Declaration	
I hereby declare that the above answers are true to the best of my knowledge and belief.	
Signature of Doctor	Address & Offical Stamp of Doctor
Name of Doctor	
Date (dd / mm / yyyy)	

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