

## ATTENDING PHYSICIAN'S STATEMENT MAJOR DISEASE/CRITICAL ILLNESS PARALYSIS

Patient's Name

\_\_\_\_\_

Attending Physician's Name

Address

\_\_\_\_\_

\_\_\_\_\_

**This section must be completed by a qualified and registered physician at the expense of the claimant.**

The above name is insured with us against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with **PARALYSIS**. To enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

### A. GENERAL INFORMATION

1. Are you the patient's usual medical doctor?  Yes  No

If yes, over what period do your records extend to?

Start date    \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_    End date    \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
                               dd                        mm                        yyyy                                dd                        mm                        yyyy

2. When did the patient first consult you for this condition?    \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
   dd                        mm                        yyyy
3. Please state symptoms presented and date symptoms first appeared.

Symptoms Presented at First Consultation	Date Symptoms First Started (DD/MM/YYYY)

What / Who is the source of this information? \_\_\_\_\_

4. In your opinion what were the likely durations of the patient's symptoms? Please provide reasons.

\_\_\_\_\_  
 \_\_\_\_\_

5. Did the patient consult any other doctors for these symptoms before he/she consulted you?  Yes  No  
 If yes, please provide details below.

Name of Doctor	Name of Clinic/ Hospital and Address



(e) What is the grading muscle strength?

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(f) Is there total and irreversible loss of use of the involved limbs?  Yes  No

If yes, please provide basis for prognosis.

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(g) Is the total and irreversible severance above the wrist or ankle?  Yes  No

(h) Did the paralysis result from a self-inflicted act?  Yes  No

If yes, please give full details.

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8. Please provide details of current treatment provided.

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9. What is the prognosis?

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10. Please provide full details of tests and results which have been performed to establish the diagnosis of Paralysis and attach copies of all relevant hospital reports, laboratory and test results, including neurological reports, CT scans, MRI and other imaging studies and surgical reports.

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11. Please provide the names and addresses of all clinics/hospitals to which the patient has been referred to or attended for this condition together with the names of doctors consulted.

Name of Doctor	Name of Clinic/ Hospital and Address

**C. MEDICAL HISTORY**

12. Has the patient previously suffered from the condition specified above or any related illnesses?  Yes  No

If yes, please provide details including date of consultations, their resulting diagnosis, the name and address of attending. Please state source of information. \_\_\_\_\_

Date of Consultation	Name of Doctor / Address	Diagnosis

13. Is there anything in the patient's medical history which would have increased the risk of Paralysis?

Yes  No

If yes, please provide details including the date of consultations and their resulting diagnosis, name and address of attending doctor. Please state source of information. \_\_\_\_\_

Date of Consultation	Name of Doctor / Address	Diagnosis

14. Please give details of the patient's family history which would have increased the risk of Paralysis (including the relationship, nature of illness, date of diagnosis) Please state source of information. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

15. 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. Please state source of information. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

16. Please give details of the patient's habits in relation to alcohol consumption, including the amount of alcohol consumption per day. Please state source of information. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

17. Does the patient have or ever had any other significant health condition(s)?  Yes  No

If yes, please provide details of the condition, including diagnosis, date of diagnosis, duration of condition(s) and treatment received.

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**D. ADDITIONAL INFORMATION**

18. Please provide us with any other additional information that will enable the Company to assess this claim.

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**I hereby certify that the above statements are true and complete to the best of my knowledge and belief.**

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**Name of Attending Physician (Please print)**

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**Degree/Specialty**

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**Signature**

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**Date Signed**

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**PRC Number / PTR Number**

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**Telephone Number (s)**

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**To the Attending Physician :** You may use additional sheets if more space is needed for the above information requested. If you wish, please send the form directly to Claims & Settlement Department with office address shown below.