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CRITICAL ILLNESS CLAIM FORM

ATTENDING PHYSICIAN'S STATEMENT

Agency/Agent's Code _____ Policy No. _____

1 This printed form issued on receipt of notice of a claim, and is no way an admission of claim.
2 This form is to be completed by the Attending Doctor at claimant's expenses.
3 The Attending Physicain is required to provide full details of your patient's condition including the history and treatment given.

Definition

Major Burns
Third degree burns covering at least twenty percent (20%) of the Life Assured's body surface area as measured by "The Rule of 9" of the Lund and Browder Body Surface Chart.

Personal Details

1 Patient's Name _____
2 I.C. No. _____
3 Age/Sex _____
4 Occupation _____
5 Main Duties _____

History

6 Are you the patient's usual Medical Attendant ? If so, since when?

_____

7 History and circumstances leading to disablity, please describe in detail, giving dates and mode of onset of the disability suffered by the patient, as related to you.

a) Date of beginning disability . ☐☐☐☐☐☐ (DD/MM/YY)

b) How did the incident happened ?

_____

c) Where did the incident occurred?

_____

8 Date of first consultation for this disability. ☐☐☐☐☐☐ (DD/MM/YY)

9 Please give details of the clinical and physical findings noted by you when the patient was first seen.

_____

_____

10 Is this disability related to any other habits or personal medical history which relates to accidents or burns? If so, please give details.

_____

Claimant's Present Condition

11 Please provide a precise diagnosis to the patient present illness

_____

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12 Please describe your patient's current symptoms.

13 Is the patient suffering from third degree burns? If no, please states the degree suffered.

14 Please state the areas of the body affected by burns.

15 Please describe the exact percentage of the body surface area affected by burns.

16 Is the patient suffering from any other condition and, if so, does it affect the condition described above?

17 How frequently does your patient consult you?

18 Since the diagnosis of his/her conditionn, has your patient :-

Recovered ☐ Improved ☐ Not change ☐ Deteriorated ☐

19 If your patient is fully recovered, please give date. ☐☐☐☐☐☐ (DD/MM/YY)

SMOKING

20 Do you have any details of your patient's smoking habit ? If so, please how many sticks per day?

What is the duration of the smoking habits?

21 Have these smoking habits, to your knowledge, changed recently ?

TREATMENT

22 Please give full details of all medicines being prescribed for your patient, including dosage.

23 Please give details of any investigation test or procedures that have been undertaken in connnection with this condition, including the result.

24 Please give details of any surgical procedure performed in connection with his/her condition.

25 Please provide details of any other treatment being prescribed, including physiotheraphy.

26 Do you anticipate changing your patient's treatment in the immediate future or recommending that he/she undergoes further investigations or surgical procedures ?

27 Is he/she still receiving treatment from any other medical practitioner ? If so, please give details.

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28 Please give the date that you last examined the claimant. ☐☐☐☐☐☐ (DD/MM/YY)

Further Information

29 Please include any further informaton which you feel would be helpful in the assessment of your patient's claim

_____

_____

30 Kindly advise us the scale of muscle power used as stated in your medical report dated 10/04/97.

_____

_____

Declaration

I hereby certify that I have personally examined the abovenamed patient and that the injuries/disability stated above represent my medical opinion of his/her current condition.

_____
Signature of Physician
Date :

Physician's Name _____
Qualification _____

_____
Clinic/Hospital Stamp Print