

MAJOR HEAD TRAUMA

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 Physician is required to provide full details of your patient's condition including the history and treatment given.

Definition

In order for a claim under this policy condition to be paid, the following definition must be satisfied :-
 Physical head injury causing significant permanent functional impairment lasting for a minimum period of three (3) months from the date of the trauma or injury. The resultant permanent functional impairment is to be verified by a consultant neurologist and duly concurred by the Company's Medical Officer and must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent", shall mean beyond the hope of recovery with current medical knowledge and terminology.

The activities of Daily Living are:-

- a) Transfer - Getting in and out of a chair without requiring physical assistance.
- b) Mobility - The ability to move from room to room without requiring any physical assistance.
- c) Continence - The ability to voluntarily control bowel and bladder functions such as maintain personal hygiene.
- d) Dressing - Putting on and taking off all necessary items of clothing without requiring assistance of another person.
- e) Bathing/ Washing - The ability to wash in the bath of shower (including getting in or out of the bath or shower) or wash by any other means.
- f) Eating - All tasks of getting food into the body once it has been prepared.

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

- 8 Date of beginning disability . (DD/MM/YY)
- 9 Date of first consultation for this disability. (DD/MM/YY)
- 10 Please give details of the clinical and physical findings noted by you when the patient was first seen.

11 Is this disability related to any other condition from which your patient has suffered in the past?
If so, please give details.

Claimant's Present Condition

12 Please provide a precise diagnosis to the patient present illness

13 Please describe your patient's current symptoms.

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

15 How frequently does your patient consult you?

16 Since the diagnosis of his/her condition, has your patient :-

Recovered Improved Not change Deteriorated

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

SMOKING

18 Do you have any details of your patient's smoking habit ? If so, please give details.

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

TREATMENT

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

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

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

23 Please provide details of any other treatment being prescribed, including physiotherapy.

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

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

DEGREE OF DISABILITY CURRENTLY BEING EXPERIENCED

- 26 Is your patient
- i Ambulatory
 - ii Confined to his/her home
 - iii Confined to bed
 - iv Subject to some other restriction in movement or lifestyle ?
- If so, please give details.
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27 How long has your patient been totally disabled from engaging in or attending to his/her usual business as a result of this disability ? Please give the date first absent from work.

28 How much longer do you consider such total disablement will continue.

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

30 Please grade your patient's function by the following scale :

1 Full function 2 Slight impairment 3 Substantial impairment 4 Nil function

	Left		Right
Knee	<input type="checkbox"/>		<input type="checkbox"/>
Legs	<input type="checkbox"/>		<input type="checkbox"/>
Hands	<input type="checkbox"/>		<input type="checkbox"/>
Arms	<input type="checkbox"/>		<input type="checkbox"/>
Shoulders	<input type="checkbox"/>		<input type="checkbox"/>
Climbing stairs		<input type="checkbox"/>	
Climbing ladders		<input type="checkbox"/>	
Walking		<input type="checkbox"/>	
Standing		<input type="checkbox"/>	
Kneeling		<input type="checkbox"/>	
Bending		<input type="checkbox"/>	
Lifting/Carring		<input type="checkbox"/>	
	With use of mechanical equipment		Without use of mechanical equipment
Transfer		<input type="checkbox"/>	<input type="checkbox"/>
Mobility		<input type="checkbox"/>	<input type="checkbox"/>
Continence		<input type="checkbox"/>	<input type="checkbox"/>
Dressing		<input type="checkbox"/>	<input type="checkbox"/>
Bathing/ Washing		<input type="checkbox"/>	<input type="checkbox"/>
Eating		<input type="checkbox"/>	<input type="checkbox"/>

31 Is there any other function impairment present ?

32 If you have indicated that there is an impairment present, can you please advise whether that impairment is permanent or temporary. If the later, can you please give an indication as to how long the impairment may last.

33 Prognosis of claimant's condition

34 When do you think your patient will be able to resume working, either to his present job or to alternative employment ?

Further Information

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

36 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