



ATTENDING PHYSICIAN'S STATEMENT

Critical Illness – Major Head Trauma

To be completed by Registered Medical Practitioner at Assured's / Claimant's own expense

Policy No.	NRIC No.	Age
Name of Assured		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
I) General Information		
1. (a) Are you the Assured's usual medical physician? (b) If "Yes", over what period do your records extend?	1. (a) <input type="checkbox"/> Yes <input type="checkbox"/> No (b) _____ _____	
2. Date of Accident	2. (a) _____ (DD/MM/YYYY)	
3. (a) When were you first consulted for this injury? (b) What was the condition during the first attendance?	3. (a) _____ (DD/MM/YYYY) (b) _____ _____	
4. (a) Was there any visible wound at the first consultation? (b) If "Yes", please describe.	4. (a) <input type="checkbox"/> Yes <input type="checkbox"/> No (b) _____ _____	
5. Please give below the details of any other doctors or specialist you have consulted in connection with this illness.		
<u>Names</u>	<u>Addresses</u>	<u>Dates (DD/MM/YYYY)</u>

6. (a) Was the injury induced from or affected by any of the following which may contribute to the accident? Please check the appropriate item.		
<input type="checkbox"/> Physical defects /congenital anomaly	_____	
<input type="checkbox"/> Degenerate changes	_____	
<input type="checkbox"/> Unfavourable past medical history	_____	
<input type="checkbox"/> Alcohol or drugs	_____	
(b) If any of the items in Q6 (a) checked, please give details.		

7. Investigations Done.		
<u>Dates (DD/MM/YYYY)</u>	<u>Procedures</u>	<u>Results</u>
(a) _____		
(b) _____		
(c) _____		

<p>8. (a) Details of Treatment Rendered</p> <p>(b) Was there any surgery performed?</p> <p>(c) If "Yes", please provide details of surgical procedures.</p>	<p>8. (a) _____ _____</p> <p>(b) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(c) _____ _____</p>
<p>9. Is the Assured permanently bedridden as a result of the head trauma?</p>	<p>9. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>10. (a) If the Assured is not bedridden, which of the following daily activities is the Assured NOT able to perform as a direct result of the trauma. Please check the appropriate item.</p> <p>(b) How long has such inability been medically documented?</p> <p>(c) Is such inability expected to be permanent?</p>	<p>10. (a)</p> <p><input type="checkbox"/> Getting in and out of a chair without requiring physical assistance.</p> <p><input type="checkbox"/> The ability to move from room to room without requiring any physical assistance.</p> <p><input type="checkbox"/> The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene</p> <p><input type="checkbox"/> Putting on and taking off all necessary items of clothing without requiring assistance of another person.</p> <p><input type="checkbox"/> The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means.</p> <p><input type="checkbox"/> All tasks of getting food into the body once it has been prepared.</p> <p>(b) _____ _____</p> <p>(c) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>11. Prognosis.</p>	<p>11. _____ _____</p>
<p>12. Has the Assured suffered from / been treated for any other illnesses or complaints other than this Critical Illness? If "Yes", please provide full details.</p>	<p>12. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>_____ _____ _____ _____</p>
<p>13. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.</p>	<p>13. _____ _____ _____</p>

Note: Please enclose copies of all reports including X-rays, CT scan, blood test, other laboratory tests, cytology, surgical report and any relevant hospital reports that are available

I hereby certify that I have personally examined and treated the Assured for his / her injuries / illnesses described above and that the facts as stated above represent my medical opinion of his / her condition.

Signature of Attending Physician

Qualification _____

Name & Address _____
(Official Stamp)

Date _____
(DD/MM/YYYY)

Contact No. _____