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MEDICAL REPORT ON TOTAL AND PERMANENT DISABILITY

Policy/Contract/Certificate No. : _____

Note : **To be completed by the regular attending doctor at the claimant's expense.**

SECTION A : PATIENT'S PARTICULARS

1. Name of patient

2. NRIC number (new) – –

3. Other identification number

4. Age years old

5. Gender ☐ Male ☐ Female

6. Date of Birth D D – M M – Y Y Y Y

7. Occupation

SECTION B : HISTORY & DIAGNOSIS

1. Full Diagnosis : _____

2. Diagnosis Date : D D – M M – Y Y Y Y

3. Last Consultation Date : D D – M M – Y Y Y Y

4. What was the underlying cause? _____

5. What were the symptoms presented? _____

6. Since when did the symptoms start? D D – M M – Y Y Y Y

7. Was the patient referred by any other doctor? ☐ Yes ☐ No

If yes, please give details.

(a) Referral Date : D D – M M – Y Y Y Y

(b) Referral Doctor : _____

(c) Clinic / Hospital : _____

(d) Referral Reason : _____

8. Does the patient have any other medical conditions or past medical history? ☐ Yes ☐ No

If yes, please give details.

Diagnosis	Onset Date	Treating Clinic / Hospital

9. Please give details of the consultation and treatment given.

Date	Treatment Details	Healing Progress

10. If the disability was caused by an ACCIDENT, please give details as follow :

(a) Accident Date : D D – M M – Y Y Y Y **(b) Time of Accident :** H H : M M am / pm

(c) Place of Accident : _____

(d) Nature of Accident : _____

(e) Injuries Sustained : _____

(f) Was the patient under the influence of alcohol / drugs? ☐ Yes ☐ No

If yes, please give details. _____

(g) Is the condition self-inflicted? ☐ Yes ☐ No

If yes, please give details. _____

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SECTION C : CURRENT HEALTH CONDITION

1. **Are you the patient's regular doctor?** ☐ Yes ☐ No **If yes, since when?** D D – M M – Y Y Y Y

2. **Last Assessment Date :** D D – M M – Y Y Y Y

3. **Please state the patient's condition as at the last date of consultation.**

☐ **Recovered (Date : _____)** ☐ **Improved** ☐ **Not Changed** ☐ **Deteriorated**

Please aleaborate.

_____

4. **Please describe the patient's limb power (reading from 0-5) [0 - No power ; 5 - Full power]**

☐ **Right Upper Limb** ☐ **Right Lower Limb** ☐ **Left Upper Limb** ☐ **Left Lower Limb**

5. **Please state the patient's current state of mobility.**

☐ **Ambulatory** ☐ **Home confined** ☐ **Bed confined** ☐ **Hospital confined**

Please elaborate.

_____

6. **Does the patient suffer from any physical impairment at the moment?** ☐ Yes ☐ No

Please give details and elaborate.

_____

_____

7. **Does the patient suffer from any mental / cognitive impairment at the moment?** ☐ Yes ☐ No

Please give details and elaborate.

_____

_____

8. **Is the patient currently suffering from any of the following :**

(a) **Total and irrecoverable loss of sight.** ☐ Yes ☐ No

(i) Please state the patient's visual acuity.

Date : D D – M M – Y Y Y Y **Right Eye :** _____ **Left Eye :** _____

(ii) Please state the degree of vision loss.

Date : D D – M M – Y Y Y Y **Right Eye :** _____ % **Left Eye :** _____ %

(b) **Total and irrecoverable loss of use of limb (at or above the wrist or ankle).** ☐ Yes ☐ No

If yes, please give details of the affected limb(s) and date.

_____

9. **Was there any amputation involved?** ☐ Yes ☐ No

If yes :

(a) **Please give details of the amputation.**

Amputation Part & Level of Amputation	Amputation Date

(b) **Has the amputation wound (stump) fully recovered?** ☐ Yes ☐ No

If yes, please state date : D D – M M – Y Y Y Y

(c) **Please state how does the patient ambulate after the amputation.**

☐ **Wheelchair** ☐ **Prosthesis** ☐ **Crutches** ☐ **Others :** _____

10. **What is your prognosis on the patient's condition? Please elaborate.**

_____

11. **Does the patient have any other medical condition that may have contribute to his/her disability?** ☐ Yes ☐ No

Please elaborate.

_____

12. **Is the patient still on regular follow-up?** ☐ Yes ☐ No

13. **Is the patient compliant to treatment?** ☐ Yes ☐ No

If the patient is compliant to treatment, would his/her condition improved? ☐ Yes ☐ No

Would he/she be able to return to work? ☐ Yes ☐ No

Please elaborate.

_____

_____

14. If the patient is no longer able to return to work, please provide details of duties / tasks that he/she is not able to perform.

_____

_____

15. Can the patient's condition be controlled with medication? ☐ **Yes** ☐ **No**

Please elaborate.

_____

_____

16. Has the patient reached the maximum medical improvement? ☐ **Yes** ☐ **No**

Please elaborate.

_____

17. Please state the patient's Whole Person Impairment (WPI) : _____ %

18. Is full recovery expected? ☐ **Yes** ☐ **No**

If yes, please state approximate date : D D – M M – Y Y Y Y

If no, please state the extent of recovery and approximate date of the stated extent of recovery.

_____

19. Please indicate how much longer the disability will last (eg. permanently or specific period, indicate the length / date).

☐ **Permanently** ☐ **Temporary** **Duration / Date :** _____

20. If the patient is currently being treated by other doctor, please give details.

Diagnosis	Doctor's Name	Clinic / Hopital

21. Please describe the patient's degree of limitation in performing the following activities :

Activities	Not Limited	Mildly Limited	Moderately Limited	Severely Limited	Incapable
Sight / Vision					
Hearing / Sound					
Reasoning / Mental faculty					
Speech					
Standing					
Sitting					
Walking					
Changing posture					
Bending					
Driving					
Squatting					
Kneeling					
Climbing Stairs					
Working with both hands					
Lifting / Carrying					
Reach above the shoulders					
Walk on uneven surface					

22. Is the patient able to perform the Activities of Daily Living (as listed below) without any assistance?

Activities of Daily Living			Remarks
(a) Transfer	☐ Yes	☐ No	
(b) Mobility	☐ Yes	☐ No	
(c) Continence	☐ Yes	☐ No	
(d) Dressing	☐ Yes	☐ No	
(e) Bathing / Washing	☐ Yes	☐ No	
(f) Eating	☐ Yes	☐ No	

23. Is the patient able to perform the following :

			Comments
(a) All normal duties of his/her usual occupation.	☐ Yes	☐ No	
(b) Return to work to his/her usual occupation on a part-time basis.	☐ Yes	☐ No	
(c) Return to work to any other form of occupation.	☐ Yes	☐ No	
(d) Performing light duties.	☐ Yes	☐ No	

24. Is the patient physically incapacitated from ever continuing in any employment? ☐ Yes ☐ No

If yes, when did such disability commence? D D – M M – Y Y Y Y

25. Is the patient mentally incapacitated from ever continuing in any employment? ☐ Yes ☐ No

If yes, when did such disability commence? D D – M M – Y Y Y Y

26. Do you consider the patient's condition to be totally disabled? ☐ Yes ☐ No

If yes, when did such disability commence? D D – M M – Y Y Y Y

27. Is the patient terminally ill? ☐ Yes ☐ No

Please elaborate.

28. Any further information which in your opinion will assist us in assessing the claim?

SECTION D : ATTENDING DOCTOR'S DECLARATION

I hereby certify that :

☐ I am the above named patient's attending doctor and I have personally examined and treated him/her for the illness/injuries sustained; **OR**

☐ I have personally perused the above named patient's medical record;

and that the facts as stated above are all true to the best of my knowledge and information that I have perused and that no material fact has been withheld from the Company.

Signature **Official Stamp** **Date :** D D – M M – Y Y Y Y

Full Name :

Hospital / Clinic :

Telephone No. :

Address :

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