Manulife

ATTENDING PHYSICIAN'S STATEMENT (PERSONAL ACCIDENT)

Policy No.
Claim No. (For internal use)

To be completed by the Attending Physician/ Surgeon at Insured's expense.

1. PATIENT'S PARTICULARS

Name of Patient: _____ NRIC/Passport No: _____

Date of Birth: _____ Sex: _____ Admission No: _____ Ward No: _____

Date of Admission: _____ Date of Discharge: _____

2. DETAILS OF PATIENT'S CONDITION

(a) Date of accident: _____/ _____/ _____
dd mm yyyy

(b) Please describe in detail how the accident happened.

_____

_____

_____

_____

(c) Please describe the nature and severity of the patient's injuries/disabilities.

_____

_____

_____

_____

(d) Were the injuries the result of the accident described above? ❑ Yes ❑ No

(e) Was the patient under the influence of alcohol or drugs at the time of the accident? ❑ Yes ❑ No

If yes, please state the following:

(i) Blood alcohol content: _____

(ii) Type of drugs consumed: _____

(f) Did the injuries result from a self-inflicted act? ❑ Yes ❑ No

If yes, please give full description.

_____

_____

_____

(g) What was patient's diagnosis? _____

Date of diagnosis (dd/mm/yyyy): _____

(h) Did the patient undergo any surgery? ❑ Yes ❑ No

If yes, please provide us the following details.

(i) Nature of Surgical Procedure Performed: _____

_____

(ii) Date of surgery performed (dd/mm/yyyy): _____

Please complete Question (i) if patient is employed, and Question (j) if patient is self-employed or unemployed.

(i) Please provide the period of medical leave given to the patient.

(i) Period of Total Disability* : From _____ To _____

Expected Date of Recovery: _____

(ii) Period of Partial Disability** : From _____ To _____

Expected Date of Recovery: _____

Notes: ***Total Disability** refers to disability which prevents the patient from performing each and every duty of his/ her occupation.

****Partial Disability** refers to disability which prevents the patient from performing one or more duties of his/her occupation.

(j) Please indicate the patient's ability to perform the Activities of Daily Living (ADLs).

Date of assessment (dd/mm/yyyy): _____

Definition of ADL	**Able to perform independently without assistance**	**Requires aid of special equipment or another person's assistance**
Washing/Bathing: The ability to wash in the bath or shower (including getting into and out of the bath and shower) or wash satisfactorily by other means.		a. Period of disability: From _____ To _____ b. Expected date of recovery: _____
Dressing: The ability to put on, takes off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.		a. Period of disability: From _____ To _____ b. Expected date of recovery: _____

Definition of ADL	Able to perform independently without assistance	Requires aid of special equipment or another person's assistance
Transferring: The ability to move from a bed to an upright chair or wheelchair and vice versa.		a. Period of disability: From _____ To _____ b. Expected date of recovery: _____
Mobility: The ability to move indoors from room to room on level surfaces.		a. Period of disability: From _____ To _____ b. Expected date of recovery: _____
Toileting: The ability to use the lavatory or otherwise managed bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.		a. Period of disability: From _____ To _____ b. Expected date of recovery: _____
Feeding: The ability to feed oneself once food has been prepared and made available.		a. Period of disability: From _____ To _____ b. Expected date of recovery: _____

(k) When did the patient first consult you? (dd/mm/yyyy) _____

List all the conditions that the patient had previously consulted you for.

_____

_____

_____

(l) Was the patient suffering from any illness/infirmity which was likely to protract the period of disability?

❑ Yes ❑ No

If yes, please provide us the details.

_____

_____

_____

(m) Did the patient consult other doctors for this condition before he/ she consulted you?

❑ Yes ❑ No

If yes, please provide the name(s) and address(es) of the doctor(s) whom he/ she consulted.

Name of Doctor	Name and Address of Clinic/ Hospital	Dates of Consultation

(n) Has the patient been admitted to hospital before for the same condition? ❑ Yes ❑ No

If yes, please provide the following details.

Date of Admission	Date of Discharge	Name of Hospital

(o) Please give any other information which you feel would be helpful in assessment of the patient's claim.

_____

_____

_____

_____

Please enclose copies of specialist or hospital reports together with any tests or similar evidence to support the validity of the patient's claim.

Signature of Doctor

Date

Address & Official Stamp

Name and Qualification (printed)