

Attending Physician's Statement – Critical Illness

Note: PLEASE SIGN ON ALL PAGES BOTTOM.

DOCTOR'S DETAILS:

Name of the Attending Physician:	
Name of the clinic / Hospital :	
Address :	
Contact No.	E-mail address :

CLAIMANT/PATIENT'S DETAILS:

Name of the Claimant :	
Address:	
Age & Sex:	Hospital/Indoor Patient Number:

SPECIFY WHICH CRITICAL ILLNESS IS APPLICABLE:

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HISTORY

Date of appearance of first symptoms: _____	
Has the patient ever had the same or similar condition in past :	Yes No
<i>(If "yes," state when and provide details. Kindly attach another sheet if required)</i> _____	

P R E S E N T C O N D I T I O N :

Subjective symptoms: _____
Objective findings <i>(include results of current X-rays, ECGs or any other special tests):</i>

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DIAGNOSIS:

Please provide details: _____

Treatment: _____

Date of first Visit: _____

OP Number / Hospital No / Indoor Patient No _____

Date of last Visit: _____ Frequency of visits(Weekly/monthly/other): _____

Date of last examination: _____

PROGRESS:

Recovered Improved Unimproved Retrogressed

MENTAL CONDITION:

Is the patient competent to endorse checks and direct the use of proceeds there of? Yes No

DECLARATION:

These statements are true and complete to the best of my knowledge and belief.

Name & Signature of the Physician: _____

Date: _____

Qualification: _____

Reg. No : _____ (Seal)

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