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:

HISTORY

Date of appearance of first symptoms: _____

Has the patient ever had the same or similar condition in past : **Yes** **No**

(If "yes," state when and provide details. Kindly attach another sheet if required) _____

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

Subjective symptoms: _____

Objective findings *(include results of current X-rays, ECGs or any other special tests)*:

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)