AVIVA

AVIVA LTD

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TOTAL AND PERMANENT DISABILITY CLAIM – PHYSICIAN'S STATEMENT

Please complete all the section in this report to the best of your knowledge. Any medical report fee will be borne by the claimant.

Name of Patient:………………………………………………..……… Sex: M/F Age:……………………….

NRIC / Passport No.:……………………………………..……… Date of Birth: ………………………………

Company: ……………………………………………………………… Occupation: ……………………………….

PART A – PATIENT'S MEDICAL HISTORY

1) Please state over what period do your records extend:

   a) Date of first consultation: (dd/mm/yyyy)

   b) Date of last consultation: (dd/mm/yyyy)

   c) Number of consultations during the above period:

   d) What were the reasons of consultations?

2) Are you the patient's usual doctor? ***YES / NO***

   a) If "Yes", since what date? (dd/mm/yyyy)

   b) If "No", please advise the name of the regular attending doctor and address of clinic / hospital.

3) Was the patient referred to you? ***YES/NO***

   a) If "Yes", please advise (i) date referred, (ii) reason the patient was referred, (iii) name of doctor recommending the referral, and (iv) name and address of clinic / hospital.

   b) If "No", how did the patient come to consult at your clinic or hospital (e.g. A&E)?

4) Have you referred the patient to another doctor(s)? ***YES/NO*** If "Yes", please advise: (a) date referred, (b) reasons for referral, (c) Name of doctor referred to and Address of clinic / hospital:

5) Does the patient have or ever have had any significant health conditions, medical history or any illness? ***YES / NO*** If “Yes”, please advise:

a) Illness | Date of First Symptoms | Date of First Diagnosis | Treatment

b) Name of the Doctor(s) (and Clinic Address) whom the patient consulted for the condition(s) stated in (a) above

c) What is the source of the above information?

PART B - PATIENT’S CONDITION
CONSULTATION FOR PRESENT ILLNESS/INJURY(IES)

1) Date you first attended to the patient for this illness or injury(ies):

2) If the condition is a result of an ***ILLNESS***, please provide the following information:

a) Details of presented symptoms:

b) Date the patient ***first*** experienced the above symptoms:

c) Date he/she first consulted for these symptoms:

d) Exact Diagnosis:

e) Date of ***FIRST*** Diagnosis:

f) Please provide the name of the doctor and clinic/hospital where the above diagnosis was first made?

g) Was the diagnosis made known to the patient? ***YES/NO*** If “Yes”, when? If “No”, why?

3) If the condition is a result of an ***ACCIDENT***, please describe injury(ies):
   a) Date and Time of accident:

   b) Describe in detail how the accident happened:

   c) Nature and extent of Injury(ies):

   d) Was the accident report to the police? ***YES/NO*** If "Yes", please enclose a copy of the police report.

   e) Was the patient under the influence of alcohol/drugs at the time of accident? ***YES/NO*** If "Yes", please state the blood alcohol content/drug type and quality consumed.

   f) Was the injury(ies) self–inflicted? ***YES/NO*** If "Yes", please provide details:

4) Did the patient consult other doctors for THIS illness or its symptoms before he/she consulted you? ***YES/NO*** If "Yes", please advise:

Name of doctor	Name & Address of clinic / hospital	Date of First & Last consultation

5) Describe type of treatment (including any operations performed or contemplated) and his/her response.

6) a) Please describe and elaborate on the nature and severity of the patient's current ***Physical*** disability and limitation.

   b) Please describe on the patient's current ***Mental*** disabilities and cognition.

c) Is his/her disability expected to deteriorate, remain static, or improve? If static, is there any reason for this?

7) a) Nature of duties of the patient's occupation before the disability:

b) Is the patient able to perform all the normal duties of his/her usual occupation? ***YES/NO***

(i) If "Yes", date the patient is expected to return to his/her usual occupation?

(ii) If "No", to what extent does the patient's disability prevent him/her from performing all the normal duties of his/her usual occupation?

(iii) If the patient is unable to return to his/her usual occupation, can he/she engage in any other type of occupation? ***YES/NO***
(Please append to this form a detailed report giving all findings relevant to the case the reasons on which you arrive at your opinion, including date such disability commenced or date the patient is expected to return to work.)

8) Is there anything in the patient's past medical history, habits or way of life relevant to the present disability? ***YES/NO*** If "Yes", please provide details.

9) Please provide us with any other additional information that will enable the company to assess this claim.

PART C - ACTIVITIES OF DAILY LIVING

	Not limited	Mildly Limited	Moderately Limited	Severely Limited	Incapable	Improvement Expected*
Seeing/Vision	☐	☐	☐	☐	☐	Yes/No
Hearing	☐	☐	☐	☐	☐	Yes/No
Speaking/ Communication	☐	☐	☐	☐	☐	Yes /No

Others, please specify : ……......

Reasoning /Thinking	☐	☐	☐	☐	☐	Yes/No
Walking	☐	☐	☐	☐	☐	Yes/No

☐ Ability to walk with aid on continuing supervision

☐ Ability to walk with aid with no supervision

☐ Ability to walk without any aid but on constant supervision

☐ Ability to walk without any aid but needed occasional supervision

Others, please specify: ……......

Climbing Stairs	☐	☐	☐	☐	☐	Yes/No
Squatting	☐	☐	☐	☐	☐	Yes/No
Using both hands	☐	☐	☐	☐	☐	Yes/No

*If yes, please indicate extent of improvement expected under the appropriate function.

Please state the patient's current limb power and any expected improvement.

Upper right limb : ....

Upper left limb : ....

Lower right limb : ....

Lower left limb : ....

Comments on the current disability and limitation: (Physical and Mental)

PART C - ACTIVITIES OF DAILY LIVING – (CONTINUED)

Please comment on whether the patient is able to perform the following activities of daily living: -

1. Washing, bathing
   Ability to wash in bath or shower or by other means to maintain personal cleanliness.

   ☐ Yes ☐ No ☐ With Assistance Required

2. Dressing
   Ability to dress and undress.

   ☐ Yes ☐ No ☐ With Assistance Required

3. Toileting
   Ability to do all the following : to get to and from the lavatory, to get on and off the lavatory, to maintain an adequate level of personal hygiene.

   ☐ Yes ☐ No ☐ With Assistance Required

4. Continence
   Ability voluntarily to control bowel and bladder function.

   ☐ Yes ☐ No ☐ With Assistance Required

5. Feeding
   Ability to consume food and drink unaided.

   ☐ Yes ☐ No ☐ With Assistance Required

6. Mobility
   Ability to move in and out of a chair or bed.

   ☐ Yes ☐ No ☐ With Assistance Required

We would be most grateful if you can provide and attach copies of any specialist or hospital reports, investigation results, etc , together with this report to assist and support this claim .

Thank you for your kind assistance.

Name of Physician : ……………………………………………………………..

Signature of Physician : ……………………………………………………………..

Clinic's Address & Stamp: ……………………………………………………………..

……………………………………………………………..

……………………………………………………………..

Date : ……………………………………………………………..