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ATTENDING PHYSICIAN STATEMENT (TOTAL / PARTIAL PERMANENT DISABILITY)

Reminders:

1. This form must be completed by the certified Medical Officer who had treated the patient.
2. Any cost incurred in relation to this report is borne by the patient.

CERTIFICATE NO.

A. PATIENT'S PERSONAL DETAILS

1. a. Name

b. NRIC No. New — — Old

c. Date of Birth (DD / MM / YY) d. Age e. Sex Male ☐ Female ☐

2. Address

Postcode Town

3. Telephone No.: Office —
House —
Handphone —

4. E-mail: _____

B. BACKGROUND

1. a. Are you the claimant's usual medical attendant?	☐ Yes ☐ No
b. If yes, how long have you been his private medical attendant?	
c. What date does your record commence?	DD MM YY
2. a. Date of first consultation for this disability.	DD MM YY
b. Date of patient first absence from work.	DD MM YY
c. Date of admission to hospital, if any.	DD MM YY
3. a. Has your patient suffered any previous episode of this disability?	☐ Yes ☐ No
b. If yes, please give details, dates and periods of absence from work.	
4. a. Is this disability related to any other condition which your patient has suffered in the past?	☐ Yes ☐ No
b. If yes, please give details including 1st date diagnose / treatment.	
5. a. Is the patient suffered any illness such as diabetes mellitus, hypertension, ischemic heart disease or etc.	☐ Yes ☐ No
b. If yes, please give details including 1st date of diagnose / treatment.	
6. Do you have reason to suspect that illness / injury is induced by the influence of alcohol or drug, pregnancy or child-birth, deliberate action, HIV infection, AIDS or mental or nervous disorder?	

C. PATIENT'S PRESENT CONDITION

1. Please describe your patient's illness and disease symptoms.	
2. Please state a precise diagnose of his/her present illness.	
3. a. Is the patient suffering from any other conditions?	☐ Yes ☐ No
b. If yes, does it affect the condition described above?	
4. Ever since the diagnosis of his/her condition, has your patient;	
a. recovered? If yes, please give date.	DD MM YY
b. improved? If yes, please give date.	DD MM YY
c. experience no changes.	☐ Yes ☐ No
d. deteriorate.	☐ Yes ☐ No
5. What particular aspect of the patient's present condition prevent him/her from returning to work?	
6. Are there any other circumstances, medical or otherwise, which may delay your patient's recovery?	

D. TREATMENT

1. Please give full details on all medicines that has been prescribed to your patient (including dosages).	
2. Please give full details on any surgical procedures performed in connection with his/her condition.	
3. Please provide details of any other treatment being prescribed including physiotherapy.	
4. Did you recommend your patient to undergo further investigation or surgical procedures?	
5. Has your patient been treated as inpatient in a hospital or other medical centres for this condition? If yes, please give full details.	☐ Yes ☐ No
6. Has your patient been an outpatient by any consultant, specialist or other member of the medical profession in connection with this condition? If yes, please give full details including the date of consultation, name of hospital and doctor's name.	☐ Yes ☐ No

Consultation date	Diagnosis	Name of doctor and address

7. Have you taken any blood pressure readings during the period of disability? If yes, please give details and dates of the readings.	☐ Yes ☐ No
8. Is your patient's height and weight wihtin normal bounds?	☐ Yes ☐ No
9. Has there been any recent fluctuation in weight? If yes, please give full details.	☐ Yes ☐ No
10. Please give details of any investigations, tests or procedures that have been undertaken in connection with this condition, including the results.	
11. Do you have any details of your patient's smoking habits? If yes, please give details.	☐ Yes ☐ No

E. DEGREE OF DISABILITY

1. a. Is your patient	☐ Ambulatory ☐ Confined to his/her home ☐ Confined to bed ☐ Subject to some restriction in movement or lifestyles
b. Please give details.	
2. a. Please tick (✓) the box on the deformities of followings: ☐ Transfer or Mobility - the ability to move from one room to an adjoining room or from one side of a room to another or get in and out of a bed or chair without requiring the physical assistance of another person; ☐ Continence - the ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene; ☐ Dressing - putting and taking off all necessary items of clothing without requiring any assistance of another person; ☐ Toileting - the ability to wash in the bath or shower, including getting in and out of bath or shower, transferring on or off the toilet and associated personal hygiene; ☐ Eating - all tasks of getting food into the body once it has been prepared.	b. Please describe in details.
3. What do you consider that your patient is capable of?	☐ Following his/her normal occupation on a full time basis ☐ Following his/her normal occupation on a part time basis ☐ Following a different occupation ☐ Cannot perform any occupation
4. What do you consider that your patient's disability to be?	☐ Total permanent ☐ Partial permanent
5. If you consider that the patient is under Partial Permanent Disability (PPD), please describe the part of the body which was under PPD. (Please draw the picture for further explaination)	
6. Please state the percentage of permanent disability of the patient (from 100% use of body), and the date commence.	

F. CLAIMANT'S PROGNOSIS

1. What aspect of your patient's disability will prevent him/her from undertaking in any work in the future?	
2. If you feel that the patient could follow a different occupation, can you give an indication as to the type of work that he/she could undertake?	
3. When do you think the patient will be able to resume working either to his present job or alternative employment?	

G. FURTHER / ADDITIONAL INFORMATION

1. Please state any information which you feel would be helpful in the assessment of your patient's claim.	
2. Do you have any diagnosis or reports from hospitals or consultants that would help our consultant medical officer to consider this claim? If yes, please provide copies or extract of such reports if you would prefer.	

H. DECLARATION

I hereby declare that to the best of my knowledge and belief the foregoing particulars in the reports are true and correct in every aspect.

_____
Signature of Medical Officer

_____
Hospital Official Stamp

Name of doctor : _____

Qualification : _____

Date : _____