Manulife

MEDICAL & ACCIDENT CLAIM - ATTENDING PHYSICIAN'S STATEMENT

(This form is to be completed by the treating doctor at the expense of the patient)

Patient's Particulars

Policy No.	
Name	
New IC/Old IC/Passport No/Birth Cert	
Date of Birth	
Present Occupation	

A DETAILS OF ILLNESS/DISABILITY

1. Hospitalisation Details	
(a) Date of Admission/Day Surgery/Outpatient:	**Date:** ..... /..... /..... **Time:** ..... **am/pm** (DD) (MM) (YYYY)
(b) Date of Discharge:	**Date:** ..... /..... /..... **Time:** ..... **am/pm** (DD) (MM) (YYYY)
2. (a) What is the Final Diagnosis?	
(b) Date first diagnosed and by which doctor:	**Date:** ..... /..... /..... (DD) (MM) (YYYY) **Doctor:** .....
(c) Was patient informed of the diagnosis? If yes, when was patient informed and by whom?	☐ **Yes** ☐ **No** **Date:** ..... /..... /..... (DD) (MM) (YYYY) **Doctor:** .....
3. (a) Date patient first consulted you for problems associated to this illness/ disability	**Date:** ..... /..... /..... (DD) (MM) (YYYY)
(b) Was patient referred to you? ***Kindly enclose a copy of the referral letter (if any)***	☐ **Yes** ☐ **No** **Name & Address of Referral Dr:** ....
4. (a) Please state all the presenting signs and symptoms at time of first consultation	
(b) Date patient first noticed or experienced the presenting signs and symptoms.	**Date:** ..... /..... /..... (DD) (MM) (YYYY)
(c) Had the patient previously received any medical consult for the above signs and symptoms prior consulting you? If yes, please indicate the doctor's name, address, date of consultation.	☐ **Yes** ☐ **No** **Date:** ..... /..... /..... (DD) (MM) (YYYY) **Doctor:** .....

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5. (a) Please state the underlying cause(s)/ pathology/mechanism of injury for the diagnosis.	
(b) Please advise all relevant contributing past history pertaining to the diagnosis.	
6. What medical advice were given to patient pertaining to the diagnosis?	
7. Can patient's condition be managed on outpatient basis? Please elaborate	☐ Yes ☐ No Details:

8. Please state all investigations tests which had been carried out.

Date (dd/mm/yyyy)	Investigation Tests	Test Results

9. Please state details of all treatment rendered/ medication given to patient.

Date (dd/mm/yyyy)	Nature of Treatment/Medication

10. If surgery was performed, please provide details of the surgical procedures.

Date (dd/mm/yyyy)	Nature of Surgical Procedure(s)	MMA/PHFSR Code	Name of Surgeon(s)

If condition was as result of Accident, please complete Question 11 to 19

11. (a) Date & Time of Accident:	Date: ..... /..... /..... (DD) (MM) (YYYY) Time: ..... am/pm
(b) Full details on how did the accident happen according to the patient	
12. (a) Were there any external and visible injuries or wounds seen as result of this accident?	☐ Yes ☐ No

(b) If yes, please describe details of the external and visible injuries or wounds

Site/Location	Type of External, Visible Injury (eg: laceration, abrasions)	Size & Depth of Injury (cm)

(c) If no, please describe any other evidence that is consistent with the accident as informed by the patient.

Site/Location	Type of Internal Injury

13. In your opinion, are the current injuries consistent with the description/nature of the accident as informed by the patient? If no, please elaborate	☐ **Yes** ☐ **No** **Details:**

14. In your opinion, is there any old/previous injuries or impairment not related to this accident or any pre-existing condition which may have contributed directly or indirectly to the current injuries or accident?

☐ **Yes** ☐ **No**

If yes, please furnish the details:

Type of Impairment or Disease	Date of 1st consultation (dd/mm/yyyy)	Date of Last Consultation (dd/mm/yyyy)	Function/Condition of Last Consultation	Name & Address of Treating Doctors

15. Please state full details of all treatment provided

Treatment	Type and Details	Treatment Start/ Applied Date (dd/mm/yyyy)	Treatment End/ Removal Date (dd/mm/yyyy)
Stitches (no of stitches)			
Physiotherapy			
Immobilisation (e.g. POP, Backslab, etc)			
Surgical Procedure			

16. Please state details of treatment given and healing progress during follow-up (from date of accident till injuries have healed)
**please continue in separate sheet if space provided is insufficient*

Date (dd/mm/yyyy)	Details/Condition of Physical Injuries (eg: wound size, infection)	Details of Treatment (eg: Dressing, Physiotherapy, Medications)	Imaging/Investigation Tests Performed & Results	Healing Progress (eg: range of movement, restriction, condition of wound, full/ partial weight bearing)

17. (a) Was the healing of the injuries straightforward or complicated?	☐ Straight Forward ☐ Complicated
(b) If complicated, please state why, the full details of the complications and was there any special treatment given?	Complications: ..... Cause: ..... Treatment: .....
(c) Is the patient now/ at the time of accident suffering from any other illness/disease which may prolong the healing of the injuries (eg: Diabetes)?	☐ Yes ☐ No Details: ..... Date First Diagnosed: .....
(d) If yes, what would be the normal healing time required if without the illnesses as per stated in (c)?	
18. Date patient started Full Weight Bearing:	Date: ..... /..... /..... (DD) (MM) (YYYY)
19. (a) Date of Last Consultation for the Injuries/ Disability	Date: ..... /..... /..... (DD) (MM) (YYYY)
(b) Describe the condition & function of the injured part on last consultation date	

Other Details

20. Has the patient previously been treated (outpatient) or hospitalised whether in this hospital or any other medical facilities for this or related illness/condition/injury or any other disease? If yes, please furnish the details.

Date of Consultation (dd/mm/yyyy)	Illness/Injury/Diagnosis	Types of treatment received/ Details of Hospitalisation	Name & Address of Doctor/Hospital/Clinic

21. Was the patient current illness/ condition/ disability caused directly or indirectly by the following? If yes, please tick and circle the applicable.

- ☐ Congenital/Hereditary Diseases
- ☐ Pregnancy/Childbirth/Miscarriage/Prenatal/Postnatal/Sterilization/Infertility
- ☐ Drug abuse/Intoxication
- ☐ Nervous/Mental/Emotional/Sleeping Disorder /Alternative Therapy
- ☐ Plastic/Cosmetic surgery/Dental care/Refractive errors correction
- ☐ AIDS/HIV/STD/VD
- ☐ Self-inflicted injuries/Suicide/Attempted Suicide
- ☐ None of the above

B ATTENDING DOCTOR'S DECLARATION

I hereby certify that the information above are full, complete and true as per record from the hospital/clinic.

_____ Date: ..... /..... /.....
(DD) (MM) (YYYY)

Signature of the Attending Doctor

Name of the Attending Doctor : .....

Official Stamp of the Attending Doctor : .....

Professional Qualification : .....

Name & Address of Hospital/Clinic : .....

Contact No. : .....