PERSONAL ACCIDENT CLAIM - DOCTOR'S STATEMENT

Note: This form is to be completed at the patient's expense by the patient's Attending Doctor.

PRUDENTIAL

Patient's Personal Details

Name

Policy Number

NRIC/Old IC/Passport/Birth Cert/Others

Date of Birth

Gender

☐ Male ☐ Female

SECTION A : Medical History of The Patient

1. Occupation

2. Nature of occupational duties

3. Date & Time of accident as related by the patient

Day Month Year am/pm

4. Date of First Consultation

Day Month Year

5. Describe in detail the nature and cause of the accident as related to you by the patient.

6. Were there any external and visible injuries or wounds as a result of this accident?

☐ YES ☐ NO

If Yes, then please describe details of the external and visible injuries.

Site	Type of External, Visible Injury	Approximate Measurement of Injury

If No, please describe any other evidence that is consistent with the accident as claimed by the patient.

Site	Type of Internal Injury

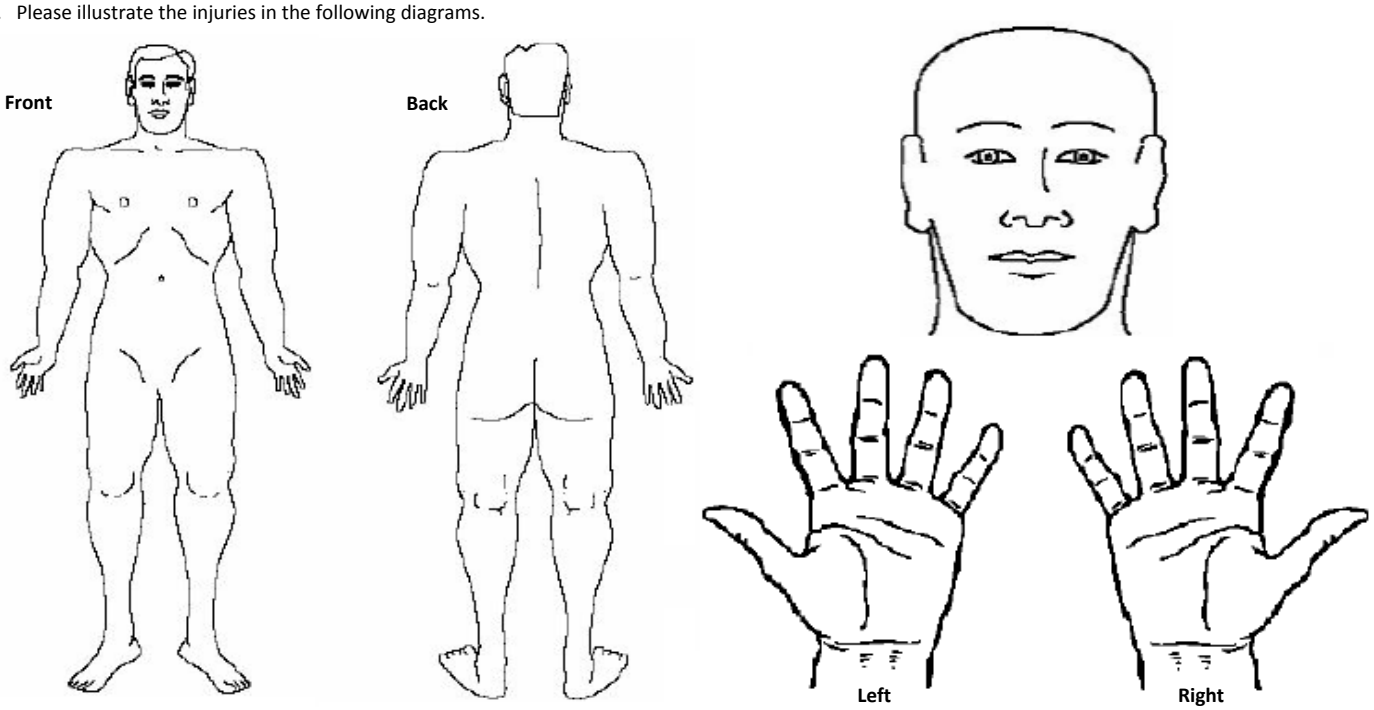
7. In the event of any amputation, please describe the level of amputation (eg. proximal, middle, distal) & percentage of loss.

Level of Amputation	Percentage of Loss

You may use the diagram in page 2 to illustrate the injuries.

8. What is the final diagnosis of the patient upon your clinical findings and/ or investigating tests results.

9. Please illustrate the injuries in the following diagrams.



10. Based on your opinion, is the patient's current bodily injury (ies) consistent with the description/ nature of the accident?

☐ YES ☐ NO

If No, please describe if the injuries are traceable to any pre-existing condition, previous injuries not related to this accident or any other cause (eg. repetitive movement, exertion, overuse) known to you.

11. Is the patient now/ at the time of the accident suffering from any illness/ disease/ infirmity/ physical deformity/ intoxication?

☐ YES ☐ NO

If Yes, please state the nature and the extent to which the patient's recovery has thereby been or may be retarded.

12. Please provide the full details of all treatments provided.

Treatment	Type and Details	Treatment Start / Applied Date (DD/MM/YYYY)	Treatment End / Removal Date (DD/MM/YYYY)
Stitches			
Physiotherapy			
Immobilisation (POP, Backslab, crepe bandage. etc)			
Surgical Procedure			

13. If the patient was immobilized, please provide the following details:

i. Date started for Full Weight Bearing ☐ Day ☐ Month ☐ Year

ii. Date of completion ☐ Day ☐ Month ☐ Year

14. Please provide the details of Limitation of Movements on any joints.

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Level 17, Menara Prudential, No. 10, Jalan Sultan Ismail, 50250 Kuala Lumpur. P.O. Box 10025, 50700 Kuala Lumpur.
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15. Treatment given including follow-ups (from date of the accident until injuries healed):

Date of Consultation (DD/MM/YYYY)	Details/Conditions of Physical Injuries	Details of Treatment (Eg. Dressing, Incision and Drainage, Medication Prescribed, etc)	Details of Healing Progress (Eg. Range of movement, condition of wound, etc)

16. Was the healing straight forward or complicated?

☐ Straight Forward ☐ Complicated

If complicated, please provide details of complications.

17. Date of Last Consultation

☐ Day ☐ Month ☐ Year

18. Describe the condition and function of injured part on last consultation.

19. Please provide the details of hospitalisation (if any):

a) Name of Hospital:

b) Date Admitted: ☐ Day ☐ Month ☐ Year

c) Date of Discharged: ☐ Day ☐ Month ☐ Year

d) Date of Surgery Performed:

e) Type of Surgery Performed:

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20. Name and address of other doctors who treated the patient for the same injury and the date of treatment.

Name & Address of Doctor	Date of Treatment (DD/MM/YYYY)

21. Please provide the details if the patient is **female**.

Was the patient pregnant at the time of accident?

☐ YES ☐ NO

If Yes, please state the gestational period and circle the applicable term.

☐ Weeks / Months

Was the accident caused directly or indirectly by the pregnancy?

☐ YES ☐ NO

If Yes, please describe in detail.

22. Is the patient employed at the time of the accident?

☐ YES ☐ NO

If No, please indicate which "Activities of Daily Living" the patient is unable to perform in the boxes below:
(either with or without the use of mechanical equipment, special devices or other aids and adaptations)

- ☐ Transfer (Getting in & out of chair without requiring physical assistance)
- ☐ Mobility (The ability to move from room to room without requiring any physical assistance)
- ☐ Continence (The ability to voluntarily control bowel and bladder function such as to maintain personal hygiene)
- ☐ Dressing (Putting on and taking off all necessary items of clothing without requiring assistance of another person)
- ☐ Bathing/ Washing (The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means)
- ☐ Eating (All tasks of getting food into the body once it has been prepared)

23. Was any X-ray/ Ultrasound/ CT scan/ MRI/ any other investigatory tests taken?

☐ YES ☐ NO

If Yes, please supply a copy of the Radiologist or related reports for our reference.

SECTION B : Attending Doctor's Declaration

I hereby certify that:

☐ I am the patient's attending doctor and I have personally examined and treated the patient for the illnesses/ injuries sustained; OR
☐ I have personally perused the patient's medical records;

and that the facts as stated above are all true to the best of my knowledge and information that I have perused.

If you are not the attending doctor, please state:

The Attending Doctor's Name & Speciality:

The reason(s) for completing this document on behalf of the Attending Doctor:

Signature : Date :

Name :

Professional Qualification :

MMC/ Registration Number :

Name & Address of Hospital/ Clinic :

Official Stamp of the Doctor :

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