TOTAL AND PERMANENT DISABILITY CLAIM - DOCTOR'S STATEMENT

Note: This form is to be completed at the patient's expenses by Attending Physician/ Surgeon who treated the patient.

PRUDENTIAL

Patient's Personal Details

Name

Policy Number

NRIC/Old IC/Passport/Birth Cert/Others

Date of Birth

Gender ☐ Male ☐ Female

SECTION A : Medical Record of The Patient

1. Height ____ cm Weight ____ kg Date Measured ____ Day ____ Month ____ Year

2. Date the patient **first** consulted you for this condition.

____ Day ____ Month ____ Year

3. The presenting signs and symptoms during the first consultation with you.

4. In your opinion, how long has the presenting signs and symptoms lasted prior to the first consultation with you?

____ Day ____ Month ____ Year

5. Please complete the following if this conditon is due to an accident.

Date & Time of Accident	Place of Accident	Details of Accident

6. Please describe the full and exact diagnosis and the diagnosis date.

Diagnosis	Diagnosis Date (DD/MM/YYYY)

7. Date the patient last consulted you for this condition.

____ Day ____ Month ____ Year

8. The presenting signs and symptoms during the last consultation with you.

9. Date when the patient was first unable to attend work due to this condition.

____ Day ____ Month ____ Year

10. Please state details of nature of treatment and medication given.

Date (DD/MM/YYYY)	Treatment/ Medication

11. Current state of mobility.

☐ Ambulatory without aid
☐ Ambulatory with aid:
☐ Home Confined

☐ Wheel Chair Bound
☐ Bed-Ridden
☐ Hospital Confined

FORM ID 11601013

12. Is the patient currently undergoing any form of rehabilitation?

☐ YES ☐ NO

If Yes, please comment on any further treatment or rehabilitation which may improve the patient's condition. (E.g. Retraining, Physiotherapy)

13. Progress of recovery. Please tick [✓] in the appropriate box.

☐ Recovered ☐ Improving ☐ Static ☐ Deteriorating

14. Please provide the full details for current Activities of Daily Living.

Activities of Daily Living	Not Limited	Limited	Incapable	Description for the condition
Transfer (Getting in & out of a 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 functions 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)				

15. Please indicate the examination of limbs' Muscle Power and Range of Movement of the various joints in the table below with maximum grade of 5.

Joints	Muscle Power		Range of Movement	
	Right	Left	Right	Left
Shoulder				
Elbow				
Wrist				
Grip				
Hip				
Knee				
Ankle				

16. With the current health condition of the patient, how would you evaluate the current working capacity of the patient?

Please select [✓] one of the relevant options.		Description of the condition
☐	Incapable of light manual duties. (I.e. slight restriction on mobility)	
☐	Incapable of heavy manual duties without restrictions. (I.e. moderate restriction on mobility)	
☐	Incapable of sedentary manual duties. (I.e. severe restriction on mobility)	

17. Please describe the current mental impairment of the patient (if any).

18. Please provide the details of the patient's ability to perform an occupation.

	Own Occupation	Other Occupation
a. Is the patient now totally disabled?	☐ YES ☐ NO	☐ YES ☐ NO
b (i) Do you expect a fundamental or marked change of this present condition in the future?	☐ YES ☐ NO	☐ YES ☐ NO
(ii) If Yes, when do you consider the patient will be able to resume work?		

19. Has the patient previously suffered from this illness or any related illness or any other illnesses for the past three years?

☐ YES ☐ NO

If Yes, please provide details as required below :

Date of Consultation (DD/MM/YYYY)	Illness/ Diagnosis	Types of Treatment Received/ Details of Hospitalisation	Investigation Result	Name of Doctor & Name of Hospital/ Medical or Healthcare Facilities

20. Was the patient referred to you?

☐ YES ☐ NO

If Yes, please provide details below and enclose a copy of the referral letter (if any):

Name & Address of Referral Doctor

SECTION B : Additional Information For Juvenile Less Than 16 Years Old

1. Is the patient confined to hospital or any health facility(ies)/ home under medical supervision?

☐ YES ☐ NO

If Yes, please provide the reason of the patient required for hospital care/ medical supervision?

What kind of treatment/ care was rendered to the patient during the confinement?

SECTION C : 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.

Signature : Date :

Name :

Professional Qualification :

MMC/ Registration Number :

Name & Address of Hospital/ Clinic :

Official Stamp of the Doctor :