HSBC Life

Attending Physician Statement - Total and Permanent Disability

Instruction to doctor: This patient is insured with us against the happening of certain contingent events associated with his health. A claim has been submitted in connection with Total and Permanent Disability (TPD). To enable us to assess the claim, please complete this report and return it directly to our company. For questions where date is applicable, please complete in the format of day/month/year.

To be completed and signed by the Attending Physician

I hereby certify that I personally examined the patient and my records and medical opinion are as follows:

1. Name of patient: _____ NRIC no. : _____

2. Are you the patient's regular medical attendant? ☐ Yes ☐ No
   If yes, please provide details beginning with the first record in your clinic:

Date(s) consulted	Purpose & details of Consultation(s)	Diagnosis	Nature of treatment rendered, including type of tests and/or surgeries done

If no, do you know the name and address of the patient's regular medical attendant(s)?
☐ Yes ☐ No

If yes, please provide details:

Name of medical attendant	Address

3. Details of the consultation

3.1 Date you were first consulted for the illness or injury leading to disability

_____

3.2 Date of all subsequent visits: _____

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3.3 State the symptoms presented, the medical history as presented by the patient and date when the symptoms first appeared.

Symptoms Presented at first consultation	Date symptoms first started

3.4 Where is the source of this information about the patient's condition? (Patient or referring doctor or others. If others, please specify)

_____

3.5 In your opinion, how long do you think the symptoms first appeared prior to consulting you?

_____

you for this medical condition or its symptoms, please provide details:

Name of doctor(s) or hospital(s)	Address of doctor(s) or hospital(s)	Date consulted or date referred to you

(Please continue with your documentation on a blank page if there are more than 3 records and attached it with this report)

4. Details of the illness or injury leading to disability

4.1 Details of diagnosis:

Doctor's diagnosis	
Diagnosis date	
Underlying cause (if any)	

4.2 Date of when patient was first informed of the diagnosis: _____

4.3 Name of doctor or hospital who first made the diagnosis:

_____

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4.4 Is the patient's condition caused by an injury due to an accident? ☐ Yes ☐ No
If yes, please provide details:

a. Date and time of accident: _____

b. Place of accident: _____

c. Described how the accident happened: _____

d. Was the patient under influence of alcohol at the time of accident? ☐ Yes ☐ No
If yes, please state the blood alcohol content: _____

e. Was the accident reported to the police?
If yes, please provide name and contact details of the police division and name of the police officer in-charge.

_____

4.5 Was the diagnosis supported by histology, radiological or laboratory evidence? ☐ Yes ☐ No

a. If yes, please state mode of investigation done and attach copies of radiology and diagnostic reports

_____

b. If no, why and on what basis did you derive at such diagnosis?

_____

4.6 Is the patient's condition in any way related or due to:

a. AIDS or HIV related illness? ☐ Yes ☐ No

b. Use of drug not prescribed by a registered medical practitioner or drug abuse? ☐ Yes ☐ No

c. Alcohol related brain damage? ☐ Yes ☐ No

d. Congenital anomaly or defect? ☐ Yes ☐ No

e. Attempted suicide or self-inflicted injuries? ☐ Yes ☐ No

If yes, please provide details and enclose a copy of the test result:

Diagnosis date	
Name and address of doctor who first diagnosed the patient with the above conditions	

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5. Details of treatment and surgery

5.1 State the full details of all treatment provided (example medication, therapy, etc.).

Nature of treatment	Date(s) of treatment

5.2 Was there any surgery performed or going to be performed? ☐ Yes ☐ No

If yes, please provide details and enclose a copy of the operation report:

Nature of surgery performed or going to be performed	Date(s) of surgery

5.3 Patient's response to the treatment: _____

5.4 Was the patient referred to other doctor(s) for follow up or further management? ☐ Yes ☐ No

If yes, please state name and address of doctor(s) or hospital(s) and the reason(s) for referral.

_____

5.5 Is the patient still on follow up treatment with you? ☐ Yes ☐ No

If yes, please state the follow up treatment plan.

_____

6 Current disability status and extent of disability

6.1 Date when the patient was last assessed for his disability status by you: _____

6.2 On the date of the last assessment under 6.1, please provide your assessment result on the patient's disability status by completing the following:

a. Describe fully the nature and severity of the patient's current physical disabilities and neurological limitations.

_____

b. How long has the neurological deficits lasted since the initial episode? Please provide its duration in weeks.

_____

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c. Are these neurological deficits likely to be permanent? ☐ Yes ☐ No
If yes, please provide details.

_____

d. State the progress of recovery of the patient:
☐ Recovered ☐ Improving ☐ Stationary ☐ Retrogressed

e. State the current state of mobility of the patient:
☐ Ambulating without aid ☐ Ambulating with aid ☐ Confined to home
☐ Confined to bed ☐ Confined to hospital ☐ Confined to wheelchair

f. If the patient is confined to a home, bed, hospital or other institution that provides constant care and medical attention, when did such confinement started?

_____

g. Does the patient have full power of all limbs? ☐ Yes ☐ No
If no, please state which limb(s) do not have full power and state the current power of the affected limb(s).

_____

h. Is the patient currently able to perform the following activities of daily living (ADL) <u>without assistance</u>?

i. Ability to feed oneself ☐ Yes ☐ No
ii. Ability to wash and bathe oneself ☐ Yes ☐ No
iii. Ability to dress, undress, secure and unfasten all garments and any surgical appliances of oneself ☐ Yes ☐ No
iv. Ability to attend to own toilet needs ☐ Yes ☐ No
v. Ability to move from a bed to an upright chair or wheelchair and vice versa ☐ Yes ☐ No
vi. Ability to move indoors from room to room on level surfaces ☐ Yes ☐ No

i. Please give full details with respect to the patient's MENTAL abilities and cognition

_____

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6.3 On the date of the last assessment under 6.1, please provide <u>your assessment</u> result on the patient's *extent of disability and his employability* by completing the following:

a. State the patient's usual occupation before disability and the nature of his normal duties

_____

b. Given the patient's current disability, is he able to perform all or partial duties of his current occupation? ☐ Yes ☐ No

If yes, please state the date that the patient has returned or is expected to return to his normal duties.

_____

If no, please elaborate how the patient's current disability has prevented him from performing the listed duties of his occupation under 6.3(a.)

_____

c. If the patient is unable to return to his current occupation listed under 6.3(a.) due to his current disability, is he able to engage in any OTHER occupation now or in the future? ☐ Yes ☐ No

If yes, provide details:

i. What type of occupation(s) and the duties is he capable of performing?

_____

ii. When is he expected to engage in the occupation(s) stated under 6.3(c.)(i.)?

_____

If no, please elaborate how the patient's current disability has prevented him from performing any other occupation now or in the future.

_____

6.4 Please give date of the next review with your clinic/hospital: _____

7 Prognosis and Rehabilitation

7.1 Is full recovery expected? ☐ Yes ☐ No

If yes, how soon is the patient expected to recover from his disability? (State the duration in weeks or months)

_____

If no, please state the extent of the patient's recovery progress and approximate date.

_____

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7.2 Please state any further treatment or rehabilitation plan and for how long it is expected to last.

_____

7.3 Please state the name and address of doctor or hospital whom the patient is currently on follow up with

_____

7.4 In your opinion, is the patient's disability "TOTAL and PERMANENT and such that there is neither then nor at any time thereafter any work, occupation or profession that the person concerned can ever sufficiently do or follow to earn or obtain any wages, compensation or profit"?

☐ Yes ☐ No

If yes, please elaborate how you derived at the conclusion.

_____

7.5 Date which such disability commenced (dd/mm/yyyy): _____

8 Regarding the patient's medical history

8.1 Has this patient previously suffered from the same condition or any related illnesses?

☐ Yes ☐ No

If yes, please provide details:

Date of when condition was first diagnosed	
Resulting diagnosis	
Name and address of doctor who attended to patient (if not attended to by you)	

8.2 Is the patient suffering from or suffered from any other medical conditions? ☐ Yes ☐ No
If yes, please provide details:

Name of doctor(s) or hospital(s) & Address	Diagnosis	Diagnosis date	Nature of treatment rendered, including type of tests and/or surgeries done

(Please continue with your documentation on a blank page if there are more than 3 records and attached it with this report)

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8.3 Is there anything in the patient's personal medical history which would have increased the risk of disability? ☐ Yes ☐ No
If yes, please provide full details, including the date of diagnosis, name and address of attending doctor and source of information.

_____

8.4 Is there anything in the patient's family history which would have increased the risk of disability? ☐ Yes ☐ No
If yes, please provide details, including relationship, nature of illness, diagnosis date and source of information.

_____

8.5 Please provide details of the patient's habits in relation to cigarette smoking, including the duration of the smoking habit, number of cigarettes smoked per day and source of information.

_____

8.6 Please provide details of the patient's habits in relation to alcohol consumption, including the amount of alcohol consumption per day and source of information.

_____

9. Please provide us with any other additional information that will enable us in assessing this claim.

_____

_____ _____
Date Name and signature of doctor

_____ _____
Address and official stamp Qualifications