HSBC Life

Attending Physician Statement - Major Head Trauma

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 When did the patient first consulted you for Major Head Trauma?

_____
(dd/mm/yyyy)

3.2 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

HSBC Life

Attending Physician Statement - Major Head Trauma

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

_____

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

_____

3.5 If the patient was referred to you OR if the patient had seen other doctor(s) before consulting 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

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:

_____

4.4 Has the patient returned or able to return to his normal duties? ☐ Yes ☐ No
If yes, please state the date that the patient has returned or is expected to return to his normal duties.

_____

HSBC Life

Attending Physician Statement - Major Head Trauma

If no, please state the patient's current physical and mental limitations and the date of your assessment.

Date of assessment	Neurological limitations

4.5 Does the patient has any of the following permanent neurological deficit(s)?

	Type of neurological deficit(s)	Please tick	Is this neurological damage likely to be permanent?
a	Numbness of limbs	❑ Yes ❑ No	❑ Yes ❑ No
b	Paralysis	❑ Yes ❑ No	❑ Yes ❑ No
c	Localised weakness	❑ Yes ❑ No	❑ Yes ❑ No
d	Dysarthria (difficulty) with speech	❑ Yes ❑ No	❑ Yes ❑ No
e	Aphasia (inability to speak)	❑ Yes ❑ No	❑ Yes ❑ No
f	Dysphagia (difficulty swallowing)	❑ Yes ❑ No	❑ Yes ❑ No
g	Visual impairment	❑ Yes ❑ No	❑ Yes ❑ No
h	Difficulty in walking	❑ Yes ❑ No	❑ Yes ❑ No
i	Lack of coordination	❑ Yes ❑ No	❑ Yes ❑ No
j	Tremor	❑ Yes ❑ No	❑ Yes ❑ No
k	seizures	❑ Yes ❑ No	❑ Yes ❑ No
l	Dementia	❑ Yes ❑ No	❑ Yes ❑ No
m	Delirium	❑ Yes ❑ No	❑ Yes ❑ No
n	Coma	❑ Yes ❑ No	❑ Yes ❑ No
o	Others, please specify _____	❑ Yes ❑ No	❑ Yes ❑ No
	_____	❑ Yes ❑ No	❑ Yes ❑ No
	_____	❑ Yes ❑ No	❑ Yes ❑ No
	_____	❑ Yes ❑ No	❑ Yes ❑ No

HSBC Life

Attending Physician Statement - Major Head Trauma

4.6 a. State the progress of recovery of the patient:

☐ Recovered ☐ Improving ☐ Stationary ☐ Retrogressed

b. State the current state of mobility of the patient:

☐ Ambulating without air ☐ Ambulating with aid ☐ Confined to home
☐ Confined to bed ☐ Confined to hospital ☐ Confined to wheelchair

c. 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?

_____

d. 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).

_____

e. 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

4.7 Has there been an infarction of brain tissue, haemorrhage or embolisation from an extracranial source? ☐ Yes ☐ No

If yes, please state which of the above.

_____

4.8 How was this diagnosis established? Please include a copy of diagnostic investigation report i.e MRI scan, CT scan etc

_____

HSBC Life

Attending Physician Statement - Major Head Trauma

4.9 Is the patient's condition or surgery performed in any way related or due to:

a. Accident? ☐ Yes ☐ No

b. Spinal cord injury ☐ Yes ☐ No

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

d. Alcohol related brain damage? ☐ Yes ☐ No

e. Congenital anomaly or defect? ☐ Yes ☐ No

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

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

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 Was the surgery performed or going to be performed a type of burr hole surgery? ☐ Yes ☐ No

5.4 Does patient required reconstructive surgery above the neck to correct disfigurement as a direct result of an accident? ☐ Yes ☐ No

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

If yes, please state the follow up treatment plan

_____

_____

HSBC Life

Attending Physician Statement - Major Head Trauma

6. Regarding the patient's medical history

6.1 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 4 records and attached it with this report)

7. 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