BDO life®

Attending Physician's Statement - Disability Claim

Note: This section must be completed by a qualified and registered physician. Costs, if any, shall be shouldered by the Claimant.

1. PATIENT'S INFORMATION

a. Name : _____
Last Name First Name Middle Name

b. Address : _____

c. Date of Birth : _____ Place of Birth : _____ Age: _____ Status: _____

2. CONSULTATION FOR CURRENT ILLNESS OR INJURY/IES

a. Date of first consultation _____ Patient's complaint(s) _____

_____

b. Symptoms experienced _____ Date symptoms first experienced _____

c. Name and Address of Hospital _____

_____

d. Diagnosis/ses _____

e. Date of Diagnosis _____ Date patient was informed of the diagnosis _____

f. Please provide brief history of patient's illness _____

_____

_____

g. If Surgical Procedure was performed, please narrate in detail the procedure and provide a copy of the Operation Room Record and Pathology Report .

_____

_____

h. If the condition was a result of an accident, please provide the following information:

Date of accident _____ Please describe the injuries sustained by the patient. _____

_____

i. Diagnosis/ses _____

3. PATIENT'S CONDITION

a. Please describe fully the nature and severity of the patient's current disability. _____

_____

b. Is the patient confined to a medical facility or house that provides constant care and medical attention? _____

c. Please comment on the patient's range of body movement _____

_____

d. Does the patient have full power/use of all limbs? _____ If No, please state which limb(s) do(es) not have full power/use and the corresponding muscle power?

_____

e. What is the likelihood of the patient's improvement in motor function over time? _____

_____

f. Please provide the patient's mental abilities and cognition. _____

_____

g. Please describe the past and current treatment/s provided, including any operations performed and whether these are likely to improve the patient's condition. _____

_____

h. Is the patient compliant with the recommended treatment program? _____ If No, please elaborate. _____

_____

i. What, if any, are other or further treatments recommended to be performed in the future? _____

_____

j. How often must the patient be on follow-up consultation/treatments for his/her condition? _____

k. Please provide full details of the patient's capabilities and limitations.

Capabilities (What the patient can do) _____

_____

Limitations (What the patient cannot do) _____

_____

l. Date the patient ceased to work _____ Date expected to return to usual occupation _____

m. Is the patient totally and permanently disabled as a result of bodily injury/ies or disease/s that he/she will be unable to engage in any occupation or perform any work for income or profit currently or at anytime thereafter? _____

If Yes, please state the commencement date of total and permanent disability _____

If the patient's condition considered partial and temporary disability? _____

n. Is the disability due to the occurrence of any of the following:

Total and irrecoverable loss of sight of both eyes	☐ Yes	☐ No
Complete loss or severance of both hands at/or above the wrist	☐ Yes	☐ No
Complete loss or severance of both feet at/or above the ankle or the severance of one hand and one foot	☐ Yes	☐ No

If you have ticked any of the above boxes, please provide details. _____

_____

o. Did the disability arise due to any of the following:

Any self-inflicted act or attempt at suicide ☐ Yes ☐ No

The patient being under the influence of any alcohol/drug ☐ Yes ☐ No

Any mental or nervous disorder ☐ Yes ☐ No

If you have ticked any of the above boxes, please provide details. _____

_____

p. Is full recovery expected? _____ If Yes, Expected Date of Recovery _____ Prognosis _____

4. MEDICAL HISTORY

a. Did the patient previously suffer from any related illness(es) that caused the present condition? _____ If Yes, please provide details:

_____

_____

b, Does the patient have family history for this condition? _____ If Yes, please provide information, such as relationship to insured, nature of illness, date of diagnosis/ses and source of information

_____

_____

c . Did the patient consult other doctors for this illness or its symptoms before he/she consulted you? If Yes, please provide the following information:

Date of Attendance	Name of Physician	Medical Institution and Address	Diagnosis/Treatment/ Procedure

d. Is the patient suffering or has suffered from any other significant illnesses? _____ If Yes, please provide details.

_____

_____

e. Please give any other information, which you feel would be helpful in the assessment of the patient's claim.

_____

_____

NOTE: Please enclose copies of specialist or hospital reports together with any tests or similar evidence in your possession to support the validity of the patient's claim.

I hereby certify that the above statements are true, correct and complete to the best of my knowledge and according to records in my possession, if any.

Executed at _____ this _____ day of _____20_____.

_____	_____
Signature Over Printed Name of Physician	Specialty
_____	_____
Address	Contact Number (s)
_____	_____
PRC Number	PTR Number