SECTION II – To be completed by the Attending Doctor (IN BLOCK LETTERS) MRN No:

PA

Policy No. _____

For Office Use:

NB : To be completed by attending doctor at patient's own expense. If space provided is insufficient, please attached separate sheet.

MEDICAL REPORT

Name: Patient Ref. No. Date of Accident:	I/C No: Age: Occupation: Time of Accident: Date first consulted:
1. Name of Referral Doctor: Date of Referral:	Address of Referral Doctor:
2.(a) Describe in detail the nature of accident as related to you by the patient.	2.(b) Describe in detail nature of illness/injury. Is condition due to pregnancy? ☐Yes ☐ No
3. (a) Were there any external and visible injuries seen as a result of this accident? (b) If yes, describe the extent of injuries including site and other characteristic features as seen by you.	3. (a) ☐ Yes ☐ No (b)
4. Are the patient's symptoms: (a) Due solely to this accident or (b) Traceable to disease infirmity or any other cause?	4. (a) (b)
5. Is the patient now or was he at the time of the accident suffering from any illness, disease or infirmity? If so, state the nature and to what extent his recovery has been or may be retarded thereby.	5.

6. Treatments given including follow-up (such as number of stitches, physiotherapy, type of dressing, etc.).

Date(s) Time (am/pm) Treatments

Stitches were removed on:

7. Name and address of other physician who treated patient for the same injury:

Name Address Approximate dates

8. Did the injuries require any of the following:

a) Hospitalisation ☐Yes ☐No. Date admitted: _____ Date discharged: _____

b) Surgery ☐Yes ☐ No. Type of surgery performed: _____

c) X-ray ☐Yes ☐No. Please enclose a copy of the X-ray report.

d) Special diagnostic procedure or treatment ☐Yes, ☐ No. Type of procedure/treatment: _____

e) Was there any limitation of movement on any joint ☐Yes ☐ No. _____
at the last day of treatment, if yes, please give details.

9. Is the patient suffering from any permanent total /permanent partial disablement (loss of use/function) due to this incident? ☐No. ☐Yes, 100% Permanent Total Disablement

☐Yes, Permanent Partial Disablement at _____% . Date of final re-assessment : _____

If yes, please also provide the date of the onset of the permanent disablement : _____

Detailed description of the permanent disablement: _____

10. Have you any reason to suppose that he was under the influence of intoxicants at the time of the accident?	

I hereby certify that I have personally examined and treated the patient for his/her injuries described above and that the facts as stated above represent my medical opinion of his/her condition.

Name: _____