ECICS Insurance

# ATTENDING PHYSICIAN'S STATEMENT

**IMPORTANT: This form is to be completed by Attending Doctor / Surgeon and at the claimant's expense**

| Name of Patient | | Name of Employer | |
|---|---|---|---|
| Date of Diagnosis *(dd/mm/yyyy)* | | Cause of Injury | ☐ Illness ☐ Others: ☐ Accident |

*Please provide full description of diagnosis*

| Are you the patient's usual medical doctor? | ☐Yes ☐No | |
|---|---|---|
| Over what period does your record extend? | Start Date *(dd/mm/yyyy)* | |
| | End Date *(dd/mm/yyyy)* | |

| Was the condition of the patient due to the followings (please tick) | *Please state the condition and elaborate fully* |
|---|---|
| ☐ Congenital anomaly or genetic defects present at birth<br>☐ Study and treatment of sleeping disorder<br>☐ Dental treatment<br>☐ Sexually transmitted disease<br>☐ AIDS or HIV infection<br>☐ Functional disorder of the mind or nervous mental disorder<br>☐ Alcoholism<br>☐ Drug addiction<br>☐ Cosmetic or plastic surgery<br>☐ Pregnancy, child-birth, infertility or sub-infertility, miscarriage, abortion<br>☐ Self-inflicted injuries | |

| Is the insured's present illness or condition caused by any other underlying disorders? | ☐Yes ☐No | *If Yes, please give details* |
|---|---|---|
| Is illness/accident arising from employment? | ☐Yes ☐No | *If Yes, please elaborate fully* |



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| Was the condition caused by an accident? | ☐Yes ☐No | *If Yes, describe the accident.* |
|---|---|---|
| Are you aware of anything in the previous medical history of the patient which might have contributed directly or indirectly, to the occurrence of the accident, or which may be likely in any way retard patient's recovery from it? | ☐Yes ☐No | *If Yes, please elaborate fully.* |
| Is condition originated before symptoms become apparent to the patient, please indicate when in your view this condition began to develop. | ☐Yes ☐No | *If Yes, please elaborate fully.* |
| Has the patient been treated previously for the same condition? | ☐Yes ☐No | *If Yes, please state when.* |
| **FOR HOSPITALISATION TREATMENTS *(if applicable)*** | | |
| Was any surgery performed for this condition? | ☐Yes ☐No | *If Yes, please elaborate fully on surgical procedures and treatments rendered.* |
| Any permanent *PARTIAL / TOTAL disablement sustained by patient as a result of the *illness / injury? | ☐Yes ☐No | *If Yes, please elaborate fully.* |

| Admission date | | ☐Actual<br>☐Expected | date of discharge | |
|---|---|---|---|---|

What were the investigations done to confirm the diagnosis?

Please advise the number of days that patient is expected to be necessarily and entirely confined to House or Hospital as the sole and direct result of the ☐injuries / ☐illness sustained

| To House | | days | To Hospital | | days |
|---|---|---|---|---|---|



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| Please provide details of treatment that has been provided. |
| --- |
| |
| What are the follow up outpatient treatments required. |
| |

**I hereby certified that the foregoing statements are correct.**

**Date:** ___________________
*(dd/mm/yyyy)*

**Signature & Stamp of Doctor:** ____________________

**Name of Doctor:** ________________________________

**Name & Address of Practicing ☐Clinic / ☐Hospital**

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________



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