


Medical Report

PLEASE USE BLOCK LETTERS | PLEASE ENSURE THAT ALL QUESTIONS HAVE BEEN FULLY ANSWERED



PLEASE NOTE:
These questions are to be completed by the main Doctor, Physiotherapist, Dentist or Chiropractor.
IMPORTANT: If you are claiming for LOSS OF INCOME this section *must* be completed by your DOCTOR.
The insured is responsible for the completion of this form and any charges incurred for its completion.

PART 8 – MEDICAL REPORT

Patient's Details

Name _____
Surname *Given Names*

Address _____

State _____ Postcode _____

Telephone (AH) _____ Telephone (BH) _____

What is disabling the patient? *(Please give a complete diagnosis of this condition)*

History

1. When did the patient first receive medical treatment for this injury? _____ / _____ / _____
2. (a) Was there a previous history of this or similar condition? **Yes** **No**
(b) *If Yes, please state the condition and advise when previous treatment was given* _____

3. (a) How long have you known the patient? _____ / _____ / _____
- (b) Are you the claimant's regular practitioner? **Yes** **No**
- (c) *If No, please advise who is* _____

Injury

1. When did the patient suffer the injury _____ / _____ / _____
2. What were the circumstances surrounding the injury? _____

Degree of Disability

1. Patient's Occupation _____
2. When was the patient obliged to cease work? _____ / _____ / _____
3. If patient is still disabled, when approximately will the patient resume:
(a) Some duties? _____ / _____ / _____ (b) Full duties? _____ / _____ / _____
4. If patient has recovered, when was the patient able to resume:
(a) Some duties? _____ / _____ / _____ (b) Full duties? _____ / _____ / _____

Treatment of present condition

1. When were you consulted? (a) Initially _____ / _____ / _____ (b) Most recently _____ / _____ / _____
2. How often has the patient consulted you? _____
3. Was patient confined to hospital? **Yes** **No**
4. *If Yes, please advise* (a) Name of hospital _____
(b) Period of Confinement From _____ / _____ / _____ to _____ / _____ / _____

PART 8 – MEDICAL REPORT – Continued.

5. Was confinement in a convalescent home necessary after hospitalisation **Yes No**
If Yes, please give details _____
6. What are the current subjective symptoms? _____
7. Please give results of any objective findings:
 (a) X-Rays _____
 (b) Other tests – *please advise tests done and findings* 1. _____
 2. _____
8. What surgical procedures have been performed? _____
9. What surgical procedures have been contemplated? _____
10. Are there any underlying conditions affecting recovery from the current condition? **Yes No**
If Yes, could you advise the nature of underlying conditions and how they affect disability and recovery:

11. Has patient any other physical or mental impairment? **Yes No**
If Yes, please describe _____
12. Please advise names and addresses of other treating physicians
 Name _____
 Address _____
 Telephone _____
13. If you have terminated treatment, please advise date _____ / _____ / _____
14. What is the current prognosis? _____
15. Are there any further remarks which may assist in assessing this condition?

16. Is there any permanent disability at present? **Yes No**
If Yes, please explain giving an estimated percentage loss of function: _____

Physician's Details

Full Name _____
 Qualifications _____
 Street Address _____
 Suburb _____ State _____ Postcode _____
 Telephone _____ Email _____
 Website _____

Signature _____ Date _____ / _____ / _____
