



PERMANENT PARTIAL DISMEMBERMENT - STATEMENT OF MEDICAL EXAMINER

SECTION B

- Section B of this form is to be completed by a legally qualified and registered medical practitioner who has treated the Participant for the injuries / illness sustained.
- Expenses incurred to obtain this report will be borne by the Participant.

Contract No:

- Name of Patient:
- NRIC No. : BC / Old IC No. : Age:
- Occupation as indicated to you :
- Date of **first** consultation with you: (dd/mm/yyyy) Time (am/pm)
- Diagnosis:
- Date of diagnosis (dd/mm/yyyy)
- What was the underlying cause and pathology of the above diagnosis?
.....
- If the cause was due to accident, please state
 - Date of Accident : (dd/mm/yyyy) Time (am/pm)
 - Describe in detail the nature of accident as related to you by the patient:
.....
 - Was the patient under the influence of intoxicating liquor, drug or narcotic at the time of accident? ☐ Yes ☐ No
- Treatment given including follow up consultation :-

Date of consultation (dd/mm/yyyy)	Treatment given	Healing Progress

10. Details of Hospitalization

Name of Hospital	Date of Admission (dd/mm/yyyy)	Date of Discharge (dd/mm/yyyy)	Type of Surgery Performed	Date of Surgery (dd/mm/yyyy)	Other Diagnosis Procedures or Treatment

- Was the patient referred to you by any doctor? ☐ Yes ☐ No
 - If yes, please indicate the name of doctor and address of the clinic / hospital.
.....
 - Please attach a copy of the referral letter, if any.

12. Date of full weight bearing (dd/mm/yyyy)
13. Was the healing complicated, eg: infection, malunion etc? ☐ Yes ☐ No
- i. If yes, please give details of complications.....
14. Did the patient suffer amputation of limbs? ☐ Yes ☐ No
- i. If yes, please stated level of amputation seen (proximal, middle, distal)
.....
15. Last date of consultation..... (dd/mm/yyyy)
16. Condition of healing / recovery of the injury / illness as at last consultation date
.....
17. Did the patient suffer any loss of use of limbs and /or fingers? ☐ Yes ☐ No
- Please state the power of patient's upper and lower limbs as at last consultation date
- i. Right Upper Limb : Right Lower Limb :
- ii. Left Upper Limb : Left Lower Limb :
18. Did the patient suffer any loss of eyes? ☐ Yes ☐ No
- Please give details on patient's Visual Acuity as at last consultation; (i) Right eye : (ii) Left eye :
19. Did the patient suffer any loss of hearing? ☐ Yes ☐ No
- Please give details on patient's hearing as at last consultation, (i) Right ear :db (ii) Left eardb
20. Does the patient suffer any limitation of movement on any joint as at last consultation date? ☐ Yes ☐ No
- i. If yes, please state the limitation and range of movement
.....
21. Please state the percentage(%) of whole person impairment according to AMA guidelines (completed by Specialist)
.....
22. If the patient was diagnosed to have High Blood Pressure and / or Diabetes, please state the recorded blood pressure or diabetes taken on him / her starting from the **first** recording done :
- | <u>Date (dd/mm/yyyy)</u> | <u>Readings of Blood Pressure</u> | <u>Date (dd/mm/yyyy)</u> | <u>Results for Blood Glucose (Fasting)</u> |
|--------------------------|-----------------------------------|--------------------------|--|
| i. | | i. | |
| ii. | | ii. | |

DECLARATION

I hereby declare that the foregoing answers and statements are complete and true to the best of my knowledge and belief and that I have withheld no material fact from the Company. I also hereby certify that the above information is correct as per record from the hospital / clinic.

Signature of Doctor : _____

Name of Doctor : _____

Telephone No. : _____

Date : _____ (dd/mm/yyyy)

Official Stamp of Doctor : _____

Qualification : _____

Fax No. : _____

Name and Address of Clinic / Hospital Official Stamp
