

Statement of Attending Physician

1. Medi	cal Doctor Information				
Doctor N	ame:	Specialist of :			
At Hospit	al/ Clinic:	Location:			
Contact I	NO Email:				
2. Gene	ral Information				
I. Patient N	lame:	Gender: DOB:			
ID Card/Pa	assport No.:				
Has the co	ndition as noted below:				
□ Death	□ Total Permanent Disability (TPD)	 □ Cancer or Critical Illness: □ Early Stage of Cancer □ Late Stage of Cancer □ Stroke with Permanent Neurological Deficit □ Heart Attack with Specified Severity □ Other (Please specify): 			
II. To the b	est of our medical examination, the Dea	ath or TPD of the patient was due to:			
☐ Illness: Date of Death/Disabled: Place of Death/Disabled:					
□ Accide	nt: Date of Accident:	Place of Accident:			
III. Health	nformation				
A. Personal Medical History:					
Fa	mily Medical History:				
1. •	1. First consultation and admission date (DD/MM/YY) • Reasons:				
	Diagnosis:				
	2. Patient's health conditions at the last consultation on DD/MM/YY:				
C. Do The patient have to receive medical treatment from another hospital/clinic?					
☐ Yes ☐ NO (If yes, please fill below detail)					
Doctor Na	me: Hospital/Clinic	name: Diagnosis:			



Complete only if patient is in the condition of Total Permanent Disability (TPD)					
I.Level of consciousness	☐ full consciousness☐ Semi-Coma	□ Confusion□ Coma			
II.Muscle power 5: active movement against full resis 4: active movement against gravity 3: active movement against gravity 2: active movement with gravity elin 1: trace movement or barely detecta 0: no muscular contraction identifie	and some resistance ninated ble contraction	 a. Right Upper Limb 0 1 2 3 4 5 b. Left Upper Limb 0 1 2 3 4 5 c. Right Lower Limb 0 1 2 3 4 5 d. Left Lower Limb 0 1 2 3 4 5 			
III.Muscle atrophy		a. Right Upper Limb ☐ Yes ☐ No b. Left Upper Limb ☐ Yes ☐ No c. Right Lower Limb ☐ Yes ☐ No d. Left Lower Limb ☐ Yes ☐ No			
IV.Activities of daily living		 a. Ambulating Do it yourself Do with assistant Can't do at all b. Bathing and showering Do it yourself Do with assistant Can't do at all c. Dressing Do it yourself Do with assistant Can't do at all d. Continence: The ability to control bladder Do it yourself Do with assistant Can't do at all 			
V.Physical performance Percentage physical function.	e of patients lost their	a. Arms % b. Legs %			
VI.Eye examination					
- Visual Acuity		a. Right Eyeb. Left Eye			
Visual FieldFundoscopy eyeground		a. Right Eyeb. Left Eyea. Right Eye			
.		b. Left Eye			



Regarding to assessment above:

- Above mentioned limbs/eyes can be recovered with proper treatment
- Above mentioned limbs/eyes can be recovered less than 50% with proper treatment
- Above mentioned limbs/eyes are total and irrecoverable loss of the use/sight or Total Permanent Disability

Another reason linked to complete and permanent death or impairment	
Suicide or murder:	
□ Wrong □ Right please specify here:	
Are patients under the influence of alcohol or drug use?	
□ Wrong □ Right please specify here:	
Conclusion:	
Date:	
Physician's Signature or Thumbprint	
Agreed by (Director of Hospital/Clinic) Date:	