FWD insurance

# Statement of Attending Physician

## 1. Doctor Information

Doctor Name: ..... Certified Medical Doctor at Hospital/Clinic: .....

Located Name :..... Location: .....

Contact Phone number :..... Email: .....

## 2. General Information

I. Patient name is: ..... Gender: ..... DoB:.....

ID Number/Passport: .....

Has the condition as noted below:

◯ Death ◯ Total Permanent Disability (TPD)

◯ Cancer ◯ Stroke with Permanent Neurological Deficit ◯ Heart Attack with Specified Severity

◯ Other _____

**II. The best of our medical examination, causing of Death or TPD of the patient was due from:**

◯ Illness Date of Death/Disabled: _____Place of Death/Disabled: _____

◯ Accident Date of Accident: _____Place of Accident: _____

**III. Health Information**

A. Personal Medical History.....

Family Medical History: .....

**B. Patient conditions while admitted at the hospital/clinic**

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 Name:..... Hospital/Clinic name:..... Diagnosis.....

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## D. Complete only if patient is in the condition of Total Permanent Disability (TPD)

| | |
|---|---|
| i. Level of consciousness | ☐ Full Consciousness ☐ Confusion<br>☐ Semi-coma ☐ Coma |
| ii. Muscle power<br>5 — active movement against full resistance (normal strength)<br>4 — active movement against gravity and some resistance<br>3 — active movement against gravity<br>2 — active movement with gravity eliminated<br>1 — trace movement or barely detectable contraction<br>0 — no muscular contraction identified | a) Right Upper Limb<br>☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5<br>b) Left Upper Limb<br>☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5<br>c) Right Lower Limb<br>☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5<br>d) Left Lower Limb<br>☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| iii) Muscle atrophy | a) Right Upper Limb Yes ☐ No ☐<br>b) Left Upper Limb Yes ☐ No ☐<br>c) Right Lower Limb Yes ☐ No ☐<br>d) Left Lower Limb Yes ☐ No ☐ |
| iv) Activities of daily living | a) Ambulating<br>☐ Do it yourself ☐ Do with assistant ☐ Can't do at all<br>b) Bathing and showering<br>☐ Do it yourself ☐ Do with assistant ☐ Can't do at all<br>c) Dressing<br>☐ Do it yourself ☐ Do with assistant ☐ Can't do at all<br>d) Continence: The ability to control bladder<br>☐ Do it yourself ☐ Do with assistant ☐ Can't do at all |
| v) Physical performance Percentage of patients lost their physical function. | a) Arms _____%<br>b) Legs _____% |
| vi) Eye examination | |
| - Visual Acuity | a) Right Eye<br>b) Left Eye |
| - Visual Field | a) Right Eye<br>b) Left Eye |
| - Fundoscopy eyeground | a) Right Eye<br>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

| The another reasone linked to complete and permanent death or impairment | | If only right<br>Please specify |
|---|---|---|
| Suicide or murder | ◯ Wrong<br>◯ Right | |
| Are patients under the influence of alcohol or drug use? | ◯ Wrong<br>◯ Right | |

Conclusion : .....

.....

.....

Date.....Month.....Year

Physician's Signature or Thumbprint

Name: _____

Agreed by (Director of Hospital/Clinic) _____Date: _____