

ATTENDING PHYSICIANS STATEMENT

Patient's Name : _____ Age : _____ Sex : _____ M/F

Address : _____

Date of first consultation : _____ Time : _____

For Accidental Injury

Nature of Injury : _____

X-Ray Taken : Yes No Date taken : _____

Diagnosis and Treatment Given : _____

Are the injuries solely due to the accident or traceable to any previous injuries / disease _____

Please mention past history with duration of any diseases, accidents or hospitalizations with details : _____

Was he under the influence of intoxicants / alcohol or drugs at the time of accident ? _____

For Sickness

Nature of Illness : _____

History of Presenting complaints : _____

Diagnosis and Treatment Given : _____

When did patient's symptoms first manifest : _____

Please mention past history with duration of any diseases, accidents or hospitalizations with details : _____

History of the following :-

Ailment	Yes / No, If yes Duration	Ailment	Yes / No, If yes Duration
Hypertension		Diabetes	
Cardiac ailments		Asthma	
Arthritis		Cancer	

Is this claimant Totally Disabled from each and every occupation ? _____

How long would the claimant be totally disabled ? _____

How long would the claimant be partially disabled ? _____

Prognosis of the ailment/injury : _____

Signature : _____ Date : _____ Reg. No. : _____

 Attending Doctor's Signature and Stamp
 Doctor's Name : _____
 Address & Phone No. : _____
