

Trauma Insurance Medical Statement

To be forwarded by claimant to MetLife with claim form. To be completed by a registered medical practitioner. The patient will incur any charge for this service.

Mark boxes with where appropriate, otherwise use block letters. Leave a box between words. +

Patient/claimant details

Title Surname

Given names

Address

Suburb State Postcode

Occupation/Profession Date of birth / /

Patient history

1 Are you the patient's usual doctor? Yes No

If 'YES', how long have you known the patient?

2 When did the patient first consult you for the present condition? / /

3 When did the present condition commence? / /

4 Please provide a summary of the patient's present condition including cause, symptoms and diagnosis:

5 Please detail a history of this condition, including all dates of consultation: (attach separate list if required)

Date of consultation	Reasons, including symptoms, diagnosis and test results	Treatment prescribed	Results	Progress of patient's condition (recovered, improved, static, deteriorated)

Patient history (continued)

- 6 Does the patient have a prior medical history related to the present condition?
If 'YES', please provide details including dates seen:

Yes No

Date	Details

- 7 Please provide details of other persons the patient has consulted for this condition:

Name	Address and phone number	Qualifications	Date(s) consulted

- 8 Has any near relative suffered from any hereditary disorders such as:

Diabetes Mental Illness Haemophilia Heart Disease
 Renal Disorder Cancer Stroke Huntington's Chorea

Please provide details:

Relationship to claimant	Disorder

Other information

Are you completing claim forms on behalf of the patient for any other company in respect of this condition? Yes No

If 'YES', please provide details:



