

# Loan Insurance Disability Claim Medical Statement

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

Policy No.	<input type="text"/>													
Title	<input type="text"/>			Surname	<input type="text"/>									
Given names	<input type="text"/>													
Address	<input type="text"/>													
Suburb	<input type="text"/>					State	<input type="text"/>		Postcode	<input type="text"/>				
Occupation/Profession	<input type="text"/>					Date of birth	<input type="text"/>		<input type="text"/>					

## 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** When would the condition have caused the patient to cease work?

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

<input type="text"/>
<input type="text"/>
<input type="text"/>



## Patient history (continued)

6 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)

7 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

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

Name	Address and phone number	Qualifications	Date(s) consulted

## Medical certification

Please complete either –

**Section 1.** If patient was unable to work; or

**Section 2.** If patient was able to work on a partial/restricted basis; or

**Section 3.** If patient has recovered



### Section 1. Inability to work

i. What period was the patient unable to perform any of the duties of his/her occupation?

Period from  /  /  to  /  /

ii. What are the patient's capabilities and limitations with respect to the above period?

Capabilities

Limitations

140102



## Your details (please print)

Title	Surname		
<input type="text"/>	<input type="text"/>		
Given names			
<input type="text"/>			
Address			
<input type="text"/>			
Suburb	State	Postcode	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Phone No.	Qualifications		
<input type="text"/>	<input type="text"/>		
Signature of Medical Practitioner	Date		
<input type="text"/>	<input type="text"/>		

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