TEMPORARY TOTAL DISABILITY CLAIM FORM
ATTENDING PHYSICIAN'S STATEMENT

Part 2 (To be completed by the attending physician at participant/covered person's expense)

Name of Patient			
Age		NRIC (New)	
Present Occupation		Gender	Male / Female

1. General Details	
a) Are you the patient's regular medical attendant?	☐ Yes, since when? _____(dd/mm/yyyy) ☐ No
b) When did your patient first consult you for this condition?	(dd/mm/yyyy)
c) Symptoms presented at that time	
d) Date of symptoms first appeared	According to patient :_____(dd/mm/yyyy) In your opinion :_____(dd/mm/yyyy)
e) Clinical and physical findings during the first consultation	
f) Please describe the exact details of your patient's present condition (medically, physically and mentally)	
g) Date last seen by you	(dd/mm/yyyy)

2. i) If the condition is due to an ACCIDENT, please provide details as below:	
a) Place, date and time of accident	Place : Date : (dd/mm/yyyy) Time : am / pm
b) Full circumstances of accident	
c) Details and extent of injury when first seen	
d) Did any other factors such as illness, physical defects, narcotics or alcohol contribute to the accident? If yes, please give details.	

2. ii) If the condition is due to ILLNESS / DISEASE, please provide details as below:	
a) Please give full details of the diagnosis.	
b) Date of diagnosis	(dd/mm/yyyy)
c) Name and address of doctor who established the diagnosis	
d) Was your patient informed of the diagnosis? If yes, when and by whom?	
e) Had your patient suffered any previous episodes of this condition or any other conditions leading to it or relating to it? If yes, please give details, including exact date of episodes or conditions.	
f) Was your patient referred to you? If yes, please give name and address of doctor concerned.	
g) Name and address of doctor(s) who attended to your patient prior to seeing you	
h) Name and address of doctor(s) who is/are treating your patient concurrently for this condition	
i) Did you refer your patient to any other doctor(s)? If yes, please provide name and address of the doctor(s).	
j) Details of treatment and progress on subsequent and last consultation.	Date: (dd/mm/yyyy) Treatment/Surgery Performed:

3. Disability Details	
a) Has the patient's condition improved, deteriorated or remained the same on last consultation date?	☐ Improved ☐ Deteriorated ☐ Remained the same ☐ Recovered
b) Is there any rehabilitation or physiotherapy that would help to improve the patient's condition? If yes, please give details.	
c) Is there any other treatment or further management would help to improve the patient's condition? If yes, please give details.	

d) Is the patient's current condition / disability expected to be permanent?	☐ Yes ☐ No				
e) If the condition is not permanent, to what extent is recovery expected and when is recovery expected to begin?					
f) Was patient granted medical leave?	☐ Yes ☐ No From_____till_____(dd/mm/yyyy) From_____till_____(dd/mm/yyyy) From_____till_____(dd/mm/yyyy)				
g) Was patient granted Light Duty?	☐ Yes ☐ No From_____till_____(dd/mm/yyyy) From_____till_____(dd/mm/yyyy) From_____till_____(dd/mm/yyyy)				
h) Please state the date when patient is medically boarded out, if any.	(dd/mm/yyyy)				
i) When was patient first confirmed to be temporary total disabled?	(dd/mm/yyyy)				
j) Can the patient resume his / her last occupation? If No, please give details on the extent and limitations.	☐ Yes ☐ No, details :				
k) Please comment on the patient's ability to perform the following by ticking (√) the relevant box.	No restriction	Little restriction	Slight restriction	Moderate restriction	Marked / severe restriction
(i) Heavy manual duties					
(ii) Light manual duties					
(iii) Sedentary duties					
l) We would be grateful for your advice on the patient's ability to perform an occupation as follows during the period of the disability:-	Own Occupation			Other Occupation (including sedentary)	
(i) Is the patient totally disabled from performing					
(ii) If yes, when do you consider the patient will be able to resume work in					

m) Has the patient returned to work and attended to any form of occupation? If yes, when was it?	☐ Yes, when was it : (dd/mm/yyyy) ☐ No	
n) Please describe the patient's power of limbs (from 0 to 5) 0 - No power 5 - Full power	Right upper limb	
	Right lower limb	
	Left upper limb	
	Left lower limb	

4. Please complete the section below if your patient was diagnosed to have Loss of Independent Existence.

Please grade your patient's ability to perform the following Activities of Daily Living (ADL).

1 Complete functional limitation in performing the ADL as described.

2 Substantial limitation in performing the ADL as described.

3 Minor limitation in performing the ADL. Assistance required on an intermittent basis or with some minor part of the activity or able to perform the ADL with the use of an aid or appliance

4 No functional limitation. Able to perform the ADL independently.

Activities of Daily Living (ADL)	Date of assessment : (dd/mm/yyyy) Please tick (√) the relevant box.			
i) Transfer Getting in and out of a chair without requiring physical assistance.	1 ☐	2 ☐	3 ☐	4 ☐
ii) Mobility The ability to move from room to room without requiring any physical assistance.	1 ☐	2 ☐	3 ☐	4 ☐
iii) Continence The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene.	1 ☐	2 ☐	3 ☐	4 ☐
iv) Dressing Putting on and taking off all necessary items of clothing without requiring assistance of another person.	1 ☐	2 ☐	3 ☐	4 ☐
v) Bathing / Washing The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means.	1 ☐	2 ☐	3 ☐	4 ☐
vi) Eating All tasks of getting food into the body once it has been prepared.	1 ☐	2 ☐	3 ☐	4 ☐

5. Have any other investigation tests or procedures been performed? If yes, please provide us the details and enclose a copy of the report.	

6. Has the patient been treated for any of the following illnesses? If yes, please provide additional information as per the table below.			
	Date of diagnosis/ Onset	Name and address of Doctor(s) consulted	Dates of consultation
Hypertension			
Diabetes Mellitus			
Hyperlipidemia			
Cardiovascular Diseases			
Asthma			
Other illnesses/ Injuries Please specify			

7. Please give other information which you feel would be helpful in the assessment of your patient's claim.

Note: Please enclose copies of all investigation reports including biopsy, cytology reports, CT Scans, imaging studies, laboratory evidence, surgical reports and all other relevant hospital reports that are available.

I hereby certify that I *have / have not seen the claimant's Identity Card number as stated above and that the photograph of which bears resemblance to the claimant whom I have examined.

I hereby certify that the answers above are full, complete and true.

_____

(Signature of Doctor)

Name : _____

Qualification : _____

Date : _____

Official Hospital Stamp