PAK-QATAR
FAMILY TAKAFUL
Together for the Future

Physician's Statement (for Disability/Illness Claims)

Completion Instructions:

1. This form may be completed by medical attendant who have treated the claimant covered in his/her -last illness.
2. Separate forms may be used for each attendant if more than one physician has attended during last illness of the claimant. However only one form is required for all contracts where the claimant was covered.
3. Please complete the form completely with legible handwriting avoiding cutting / overwriting.
4. This form should be duly attested by notary public, Nazim of a union council or above, executive of Pak-Qatar Family Takaful Limited or class I officer of the federal/provincial government.
5. Each section title is shaded gray.

Plan No(s)			

Information about the Claimant

a. Name:	b. Date Of Birth :	c. Gender : ☐ M ☐ F
d. Marital status (S/D/W/O):	e. CNIC No:	
f. Address of the claimant :		g. Occupation :

History

a. Date symptoms first appeared or accident occurred	b. Date patient ceased to work because of incapacity	
c. Has patient ever had the same or similar conditions? ☐ Yes ☐ No ☐ Don't know	d. If yes, please state when and describe:	
e. Is injury due to the patient's employment? ☐ Yes ☐ No ☐ Don't know	f. if diagnosis is pregnancy, give expected date of delivery: DD/MM /YYYY	
g. n) Please provide name(s) and specialty(ies) of other treating physicians:	h. Patient's current height:	i. Patient's current weight:
j. Primary diagnosis:	k. Additional conditions or complications:	
l. Subjective symptoms (including severity and frequency):		
m. Findings (please enclose a copy of current X -ray, ECGs, laboratory findings, and any clinical findings):		

Physical capacity

Describe functional capabilities, specifying continuous length of time of weight borne while:

☐ Sitting	☐ Standing	☐ Walking	☐ Lifting	☐ Carrying	☐ Bending
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Treatment dates

a. Date of first visit for current condition: DD/MM /YYYY	b. Date of most recent visit: DD/MM /YYYY	c. Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify) _____

Nature of Treatment

a. Medications (including prescribed dosages):

b. Surgeries (completed or anticipated):

c. Other:

d. Is patient following recommended treatment?

☐ Yes ☐ No (please elaborate)

Confinement to Hospital (If Applicable)

Name of Hospital	Date From	Date To	Treatment Provided

Cardiac (if applicable)

Please forward copies of exercise stress test, angiogram, or other relevant documentation.

b. Last three blood pressure readings (indicate dates):

1) _____

2) _____

3) _____

a. Functional capacity (as defined by the New York Heart Association):

— Level 1 (no limitation) _____

— Level 2 (mild impairment)_____

— Level 3 (moderate impairment)_____

— Level 4 (severe impairment)_____ _____

Progress

Has patient :

☐ recovered? ☐ improved? ☐ not improved? ☐ retrogressed?

a. Precipitating chronological events:

b. Pre-morbid personality:

c. Relevant current dynamics:

d. Changes in ADL habits:

e. Progress with treatment plan:

f. Are patient's symptoms due to drug or alcohol abuse?

☐ Yes ☐ No

g. If yes, is patient enrolled in a substance abuse programme?

☐ Yes ☐ No

h. If yes to g, state facility:

Restrictions

What precisely is preventing your patient from returning to work?

Prognosis

Prognosis for medical recovery:

Other factors affecting recovery:

Rehabilitation

Is patient a suitable candidate for medical rehabilitation services?	Is patient a suitable candidate for vocational rehabilitation?
☐ Yes ☐ No	☐ Yes ☐ No

Remarks

Please provide any comments or pertinent details that you think would be helpful in adjudicating your patient's claim for disability benefits:

Date: DD/MM/YYYY	Signature:
Qualifications:	Registration/License No:
Name (printed):	Address:
Doctor's stamp:	
Witness Signature:	Name: Address: