PAK-QATAR
FAMILY TAKAFUL
Together for the Future

Physician's Statement – DS2 (Disability Claim Form)

Note : All answers must be in the physician's handwriting

Patient Information

Name of Patient	Date of Birth
Patient's Address	

Employer Information

Name of Employer

1. History

(a) Date doctor first consulted due to disability _____ DD-MM-YYYY

(b) Date symptons first appeared or accident happened _____ DD-MM-YYYY

(c) Date patient ceased work because of disability _____ DD-MM-YYYY

(d) Has patient ever had same or similar condition? ☐ No ☐ Yes, state when and describe

(e) Is condition due to injury or sickness arising out of patient's employment? ☐ No ☐ Yes, state when and describe

(f) Name the first doctor with full address, consulted by the claimant for the above disability/accident?

Name of Doctor	Mobile No
Address	

2. Diagnosis

(a) Date symptons first appeared or accident happened _____ DD-MM-YYYY

(a) Diagnosis (including any complications)

(c) Subjective symptoms

(d) Objective findings (including current X-rays, ECG's, Labortory data any clinical findings):

(1) Clinical Findings _____

(2) Diagnosis Studies and results: _____

3. Progress

(a) Patient is	☐ Ambulatory	☐ Bed Confined	☐ House Confined	☐ Hospital Confined	
(b) Patient has	☐ Recovered	☐ Improved	☐ Stabilized	☐ Retrogressed	

4. Prognosis

(a) Is the disability presumed to be reversable ☐ Yes ☐ No

(a) Is patient now capable of performing duties of ☐ Yes ☐ No

(c) What duties of his or her job is patient incapable of performing? _____

(d) Do you expect a fundamental or marked change in future? ☐ Yes ☐ No

If yes, patient should recover sufficiently to perform duties on or about _____ DD-MM-YYYY

If No, Please explain _____

(e) Specify the date by which you presume that the patient will be able to resume his duties/work

☐ Totally ☐ Partially ☐ Temporarily ☐ Permanently

Remarks

Declaration: I hereby declared that the above statements are true and complete to the best of my knowledge.

Attending Physician's Name	
Address _____	Telephone No _____
Speciality _____	Date _____ Signature

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