TOTAL & PERMANENT DISABILITY CLAIM
Attending Physician's Medical Report

FWD insurance BSN

Policy No.:

Name of Patient: **Age :**

NRIC No.: **Gender :** ☐ Male ☐ Female

PLEASE COMPLETE THIS SECTION IF THE CONDITION WAS DUE TO ACCIDENT

1. Please provide details of accident

a) Date and time of accident — a) ☐☐ – ☐☐ – ☐☐☐☐ (DD-MM-YYYY) Time ☐☐☐☐ am/pm

b) Where did the accident occurred? — b)

c) Please described in detail how the accident happened? — c)

d) Was the patient under the influence of alcohol / drugs at the time of accident? — d) ☐ Yes ☐ No

If "YES", state alcohol content / drug type

e) Is the condition self –inflicted? — e) ☐ Yes ☐ No

If "YES", please provide details — Details

MEDICAL HISTORY

2. Are you the patient's usual medical physician? ☐ Yes ☐ No

a) If "Yes", since when? — a) ☐☐ – ☐☐ – ☐☐☐☐ (DD-MM-YYYY)

b) Please state the reason for the FIRST consultation. — b)

c) Please state the symptoms presented during FIRST consultation — c)

d) Date when the symptoms FIRST appeared — d) ☐☐ – ☐☐ – ☐☐☐☐ (DD-MM-YYYY)

e) Did the patient see other medical practitioners prior to seeing you for the current condition? — e) ☐ Yes ☐ No

If "YES", please state name & address — Name of Doctor / Hospital / Clinic

f) Has patient previously suffered from other illnesses? — f) ☐ Yes ☐ No

If "YES", please provide details — Details

PRESENT DIAGNOSIS

3. Diagnosis Details

a) Please state the diagnosis made — a)

b) Date of the diagnosis made — b) ☐☐ – ☐☐ – ☐☐☐☐ (DD-MM-YYYY)

c) What is the underlying cause of the illness for the diagnosis above? — c)

d) Date when the diagnosis made known to the patient or to the patient's family? — d) ☐☐ – ☐☐ – ☐☐☐☐ (DD-MM-YYYY)

e) Please provide details for doctor / hospital whom FIRST diagnosed the above — e)

DETAILS OF DISABILITY

4. Last examination / consultation date	☐☐ – ☐☐ – ☐☐☐☐ **(DD-MM-YYYY)**
5. Please describe fully nature of patient's disabilities	
a) Are there any abnormal movements or abnormal gait? (Please provide full details)	**a)** _____
b) Is there any muscle wasting?	**b)** _____
c) Please state patient's current condition	**c) Current condition (please tick)** ☐ **Ambulatory** ☐ **Confined to his/her home** ☐ **Confined to bed** ☐ **Other restriction in movement of lifestyle**

NEUROLOGICAL ASSESSMENT

6. Please provide the details of your assessment on patient's medical condition

a) Muscle Power - Please indicate the muscle power (1 to 5) with the maximum grade of 5

Upper Limbs	Right	Left	Remarks
Shoulder			
Elbow			
Wrist			
Grip			
Lower Limbs	**Right**	**Left**	**Remarks**
Knee			
Hip			
Ankle			

b) Sensory - Please indicate the level of motor lesion

Upper Limbs	Right	Left	Remarks
Lower Limbs	**Right**	**Left**	**Remarks**

c) Reflexes - Please indicate the response of reflexes

Upper Limbs	Right	Left	Remarks
Biceps			
Triceps			
Supinator			
Lower Limbs	**Right**	**Left**	**Remarks**
Knee Jack			
Ankle			
Plantar			

d) Range of Motion - Please state the range of movement

Upper Limbs	Area	Right	Left
Shoulder	Flexion		
	Extension		
	Abduction		
	Adduction		
	Internal Rotation		
	External Rotation		
Elbow	Flexion		
	Extension		
	Supination		
	Pronation		
Wrist	Flexion		
	Extension		
	Ulna Deviation		
	Radial Deviation		

7. Other Nature of Disability

a) Vision (Visual Acuity)

	Right	Left
Normal		
Impaired		
Scores based on Metric Acuity		

b) Hearing (Supported by an Audiometry results)

	Right	Left
Normal		
Impaired		
Scores based on Metric Acuity	dB	dB

c) Function of Speech

☐ Clear & Understandable ☐ Slurred ☐ Unable to speak

d) Cognitive function

☐ Normal ☐ Poor Comprehension

☐ Difficult with logic and reasoning ☐ Memory Loss

8. a) Date of Assessment of Activities of Daily Living ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY

Note: Please tick (✓)

Activities Daily Living (ADL	Full Function	Slight Impairment	Severely Impairment	Incapable
Transfer *Getting in and out of a chair without requiring physical assistance*				
Mobility *Ability to move from room to room without requiring any physical assistance*				
Continence *Ability to voluntarily control bowel & bladder functions such as to maintain personal hygiene*				
Dressing *Putting on & taking off all necessary items of clothing without requiring assistance of another person*				
Bathing / Washing *Ability to wash in the bath or shower (including getting in & out of bath or shower) or wash by any other means without assistance of another person*				
Eating *All task of getting food into the body without assistance of another person*				

b) What is the patient's disability Prognosis?	☐ **Worsening** ☐ **Stagnant** ☐ **Recovering**
c) Is further recovery expected? **If "YES" please state approximate period take for full recovery from now.** **If "NO" please state the extent of recovery expected and the time length.**	☐ **Yes** ☐ **No** _____ _____ _____
OCCUPATION DETAILS	
9. What was his/her occupation before the disability including the exact duties?	
10. Would the patient able to perform all the normal duties of his / her usual occupation? **If "Yes", when is he/she expected to return to his/her usual occupation?**	☐ **Yes** ☐ **No** **Date** ☐☐ – ☐☐ – ☐☐☐☐ **(DD-MM-YYYY)**
11. If he/she is unable to return to his/her usual occupation, is he/she able to engage in any other occupation? **a) If "No", please elaborate in details the reason** **b) If "Yes", what type of occupation that he/she will be able to do/engage to obtain wages, compensation or profit?**	☐ **Yes** ☐ **No** **a)** _____ _____ **b)** _____
12. Is the patient physically or mentally incapacitated from ever continuing in any employment? **If "Yes" when did such disability commence**	☐ **Yes** ☐ **No** **Date** ☐☐ – ☐☐ – ☐☐☐☐ **(DD-MM-YYYY)**
13. If he/she is mentally incapacitated, would he/she be able of receiving or handling money?	☐ **Yes** ☐ **No**
OTHER INFORMATION	
14. If the incapacity of the patient cannot be confirmed upon examination or ascertained at this moment, would you recommend a review of his/her condition in near future? **Please state the next review of / examination of the condition scheduled**	☐ **Yes** ☐ **No** **Date** ☐☐ – ☐☐ – ☐☐☐☐ **(DD-MM-YYYY)**
15. Please provide any additional information that will enable the Company to assess this claim.	_____ _____

Declaration – To be Completed By The Attending Physician / Specialist

I, the undersigned, certify that I have examined the above patient and that I have answered the above questions are true and to the best of my knowledge and belief.

Name : _____

Address : _____

_____

Date : _____

Signature and Practice Stamp (with qualification)

Important Notice :

- All reports are to be submitted directly in a sealed envelope to the address stated below and stamped **"Private & Confidential"**

  Claims Department, Level 21, Mercu 2, KL Eco City, No. 3 Jalan Bangsar, 59200 Kuala Lumpur.

- Please attach certified true copy of relevant test results or imaging reports available
- All expenses in procuring this medical report shall be borne by the claimant