

Medical Practitioner's Statement

The claimant is responsible for any fee for this statement. This form should be completed and returned to ACE Insurance promptly.

Patient's details

Patient's full name _____

Date of birth ____ / ____ / ____

Diagnosis

(If fracture or dislocation, describe nature and location ie: simple, compound)

Does the patient have any other injury that is contributing to the condition?

No Yes, give details _____

Was the disability accident related?

No, give details Yes _____

Date of accident/first symptoms

____ / ____ / ____

When did the patient first consult you for this condition?

____ / ____ / ____

How long have you been the patient's usual doctor/medical practice?

____ years

Name of patient's usual doctor/medical practice

Has the patient had surgery or is it anticipated?

No Yes, give details _____

Date performed or anticipated ____ / ____ / ____

Give name of hospital _____

Did you provide other medical services (including pathology) to the patient?

No Yes, give details

Date ____ / ____ / ____ _____

Date ____ / ____ / ____ _____

Please turn over >

Was the patient referred by you or to you?

No Yes, give details

Please provide name and address of referring doctor

Name: _____

Street address _____

_____ City _____ State _____ Postcode _____

Date of referral ____ / ____ / ____

Is the patient still disabled?

No Yes, if yes, how long will the patient be:

• totally disabled (unable to return to their pre-injury education)

from ____ / ____ / ____ to ____ / ____ / ____

• partially disabled (unable to return to a substantial part of their pre-injury education)

from ____ / ____ / ____ to ____ / ____ / ____

If partially disabled, what educational activities could the patient perform and how many hours a week?

_____ hours per week _____

Has the patient ever had the same or similar condition?

No Yes, give details _____

Has the patient requested medical evidence for the current disability to be issued to any other insurance company, accident commission, sports body or any other insurance body?

No Yes, give details _____

Name of company and claim number _____

Contact name and telephone number _____

Remarks

Please complete claim form and return to:

Signature

Signature of medical practitioner _____

Name (in print) _____

_____ Date ____ / ____ / ____

Qualifications _____

Street address _____

City _____ State _____ Postcode _____

Telephone (____) _____



ACE Insurance Limited
GPO Box 4907 Sydney 2001
Phone (02) 9335 3355
Fax (02) 9231 3697