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

____

____

____

Signature

Signature of medical practitioner ______________________________

Name *(in print)* ______________________________

______________________________ Date _____ / _____ / ______

Qualifications ______________________________

Street address ______________________________

____

City ______________ State ________ Postcode ______________

Telephone (___) ______________

Please complete claim form and return to:

SM

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

AON