Group Cover

Medical report form for TPD claims

This form is to be completed by the treating doctor/specialist.
Costs incurred for the completion of this form are the patient's responsibility.

1.0 INSURED PERSON'S DETAILS

1.1 Policy number _____ 1.2 Patient name _____

1.3 Date of birth D D / M M / Y Y Y Y

2.0 MEDICAL DETAILS

2.1 Primary diagnosis/problem _____

_____

2.2 Date of onset D D / M M / Y Y Y Y 2.3 Date of initial consult for this condition D D / M M / Y Y Y Y

2.4 Symptoms _____

_____

_____

OR if no symptoms and the condition was identified by way of a routine screening, please confirm:

Date of screening D D / M M / Y Y Y Y Screening procedure _____

2.5 What date was the patient advised of their diagnosis? D D / M M / Y Y Y Y

2.6 Is this the first episode of this or a similar condition? Yes / No

If **no**, please advise date(s) of previous episode(s) and treatment:

_____

_____

2.7 What is the current treatment plan?

_____

_____

2.8 If surgery is planned, please confirm the date and procedure:

Procedure _____ Date D D / M M / Y Y Y Y

3.0 MEDICAL CERTIFICATION

3.1 Have you advised the patient to cease work? Yes / No

If **yes**, date you advised the patient to cease work D D / M M / Y Y Y Y

3.2 If you have not advised the patient to cease work, have you advised them to reduce their hours or duties? If **yes**, please detail:

(a) Hours to work per week H H

(b) Duty restrictions _____

_____

Protecting the NZ way of life

3.0 MEDICAL CERTIFICATION (cont.)

3.2 (c) Duties able to perform:

3.3 Which particular symptoms are affecting work capacity?

3.4 Date you plan on reviewing work capacity D D / M M / Y Y Y Y

4.0 TREATMENT & REHABILITATION PLAN

4.1 What is the current treatment plan?

4.2 Medications prescribed for this condition:

4.3 Has the patient been referred to, or are you considering referring the patient to any other practitioner for opinion, treatment or rehabilitation? Yes / No

If **yes**, please provide details below:

Name Speciality

Name Speciality

4.4 Has a Graduated Return to Work plan been discussed with the insured person? Yes / No

If **yes**, please outline the plan below:

5.0 CONTACT

5.1 Would you like us to contact you in relation to this patient? Yes / No

Telephone Best time to call

6.0 PLEASE ENCLOSE

Please enclose copies of all consults, specialist reports, investigations, tests and referrals in relation to this condition.

DECLARATION

I confirm that I have examined this patient and that the information provided is complete and accurate.

Doctor name

Signature

Date D D / M M / Y Y Y Y

PRACTICE STAMP