Group Cover

Medical report form for IP claims

*This form is to be completed by the attending doctor and attached to your Income Protection Claim Form
*Please note 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 DD / MM / YYYY

2.0 DIAGNOSIS(ES)

2.1 Primary diagnosis/problem

2.2 Date of onset DD / MM / YYYY

2.3 Date of initial consult for this condition DD / MM / YYYY

2.4 Current symptoms

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

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

2.6 Are there any secondary diagnoses/problem list that may impact on their work capacity or recovery? Yes / No

If **yes**, please list the diagnoses/ problem list:

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 DD / MM / YYYY

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 HH

(b) Duty restrictions

(c) Duties able to perform

3.3 Which particular symptoms are affecting work capacity?

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3.0 MEDICAL CERTIFICATION (cont.)

3.4 Date you plan on reviewing work capacity DD / MM / YYYY

3.5 Anticipated return to work date:
(a) Part time/restricted duties DD / MM / YYYY
(b) Full time DD / MM / YYYY

3.6 Are you completing any other medical certificates for this patient? Yes / No

If **yes**, for whom:

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 the information provided is complete and accurate.

Doctor name:

Signature:

Date: DD / MM / YYYY

PRACTICE STAMP:

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