Group Cover

Medical report form for terminal illness 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 How long have you treated the patient for this illness? ______________

2.3 Date of symptom onset D D / M M / Y Y Y Y

2.4 Date you first examined the patient for this illness D D / M M / Y Y Y Y

2.5 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 ______________

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

2.7 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:

____

2.8 What is the current treatment plan?

____

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

Procedure ______________ Date D D / M M / Y Y Y Y

2.10 Has the patient been following the recommended course of treatment? (Please give details)

____

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2.0 MEDICAL DETAILS (cont.)

2.11 Please provide any further information relevant to this patient's illness, treatment or recovery:

2.12 Given your knowledge of the patient's condition and your knowledge of the type of illness and treatment available, please provide your medical opinion regarding how long you think this patient is likely to survive (in months):

2.13 Please comment on the progression of the illness:

3.0 CONTACT

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

Telephone

Best time to call

4.0 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

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