



Disability claim medical report

This form is to be completed by the Claimant's Medical Practitioner.

If there is insufficient space for you to answer any questions please attach further details on a separate sheet.

Date

Dear doctor

Your patient is making a disablement claim and we write to you to obtain information concerning his/her history. Your report will be used by AXA Australia and the Policy Owners of any relevant plans insured by AXA Australia. You should be aware that your report may be provided to your patient should access be requested or otherwise thought to be desirable by AXA Australia as part of its claims process.

Please complete the report as fully as possible from your present knowledge, or from notes recorded by any colleagues in your practice regarding any relevant conditions. It is not necessary for you to specifically see or examine the person for the purpose of this report.

Please note if there is a charge for completion of this report, it is the responsibility of your patient.

The patient:

Surname

Given names

Maiden name (if applicable)

Occupation

Date of birth

AXA policy number (if known)

Name of plan (if known)

Yours faithfully,

Elio Garino

General Manager - Financial Protection Operations
Australia & New Zealand
AXA Australia

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Section A – Patient details

1 Are you the patient's regular doctor? Yes No

(a) If 'No', please advise the name and address of his/her regular doctor.

(b) Please also provide details of other doctors seen by the patient in connection with this injury/sickness

Date of visit(s)	Name and address of doctor	Qualifications
/ /		
/ /		
/ /		

(c) How long have you known the patient personally? professionally?

2 What is the principal diagnosis of the current injury/sickness?

3 When was the patient first aware of the condition?

Date

4 On what date did the patient:

(a) First attend you for any reason?

Date

(b) First attend you for the current injury/sickness?

Date

5 On what date did the current injury/sickness first occur?

Date

6 List all dates the patient has attended you for this injury/sickness

Section B – Medical details

1 (a) Please state the history of the injury/sickness, including the exact nature and severity of the condition and give particulars of any treatment which has been or may be necessary.

(b) Please also provide full details and results of any tests performed (please include copies).

(c) What medical, surgical, rehabilitation or other treatments has the patient undergone?

(d) What is the current treatment plan?

(e) What is the future/anticipated treatment plan?

(f) What is the prognosis?

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2 Has hospital admission been necessary? Yes No

If 'Yes', please provide the name of the hospital(s) and relevant dates.

Name of hospital	Reasons for admission	Date of admission	Date of discharge
		/ /	/ /
		/ /	/ /
		/ /	/ /

3 Has the patient suffered previously from the same or related condition? Yes No

If 'Yes', please provide details.

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4 In respect of the patient's current injury/sickness, have you given any certificate to another insurance company, or in connection with workers compensation, social security, sick leave benefits from the patient's employer or for any other reason? Yes No

If 'Yes' please provide details.

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5 Are there any concurrent conditions? Yes No

If 'Yes', please provide details.

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Section C – Occupation details

1 What were the usual duties of the patient's normal occupation?

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2 Did the patient work: Full time Part time Casual

3 In your opinion on what date was the patient first unable to perform all the usual duties of his/her normal occupation as a result of the injury/sickness? Date

(a) In your opinion, do the limitations and restrictions that you have outlined above totally prevent the patient working in his/her usual occupation?
 Yes No

(b) Indicate the date the incapacity to work (if any) began. Date or Not applicable

(c) If the patient is currently unable to work, when do you expect that these restrictions/limitations will improve to enable a return to work:

- On a part-time basis? Date or Not applicable
- On a full-time basis? Date or Not applicable
- On a full-time but restricted basis? Date or Not applicable

Please provide additional information if applicable.

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Disability claim medical report (continued)

4 In your opinion, at the current time, can the patient perform any duties of his/her normal occupation? Yes No

If 'Yes':

(a) Which work duties is the patient able to perform and from what date?

Duties

Date

	/ /
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(b) Which work duties is the patient unable to perform?

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5 Is the patient able to perform any kind of work? Yes No

If 'Yes', please provide details.

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6 (a) Do you expect the patient to ever fully return to the usual duties of his/her normal occupation? Yes No

(b) If 'No', do you think the patient will ever be able to do a job for which he/she is reasonably suited by education, training or experience?

Yes No

(c) If 'Yes', please list examples of jobs which in your opinion would be appropriate.

7 Has any rehabilitation been considered for the patient? Yes No

(a) If 'No', please outline why this has not been considered.

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(b) If 'Yes', please provide details.

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8 If you think the patient will never return to any type of work, please give detailed reasons for this.

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Section D – Physician's details

Name (please print)

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Qualifications

Speciality

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Telephone

Facsimile

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Practice name and address

Town/Suburb

State

Postcode

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I/We certify that the information provided in this medical report is true and correct.

Signature

Date

X	/ /
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