Medical Practitioner's Statement

The *Medical Practitioner's Statement* must be completed by a qualified medical practitioner only such as a Doctor, Surgeon or Physician, not a health professional such as a physiotherapist, chiropractor etc.

The insured is responsible for completion of this form without expense to SLE

1. Name of Patient _____
2. Address _____
3. Date of Birth ____/____/____
4. Occupation _____
5. Gender ☐ Male ☐ Female
6. Are you the regular treating practitioner of this patient?
   - □ Yes, I have treated this patient since _____ *(year)*
   - □ No, the name and address of the regular treating practitioner that the patient is:

   _____

   _____
7. Please provide a complete diagnosis of the condition: _____

   _____

   _____
8. On what date did a medical practitioner initially treat the patient? ____/____/____
9. On what date did the patient consult you for this condition:
   a. Initially? ____/____/____
   b. Most recently? ____/____/____
10. On how many occasions has the patient consulted you for this condition? _____ *(no. of consults)*
11. Was the patient admitted to hospital?

    ☐ No ☐ Yes:

    From ____/____/____ to ____/____/____

    Name and address of hospital _____

    _____

    _____

    Was surgery performed?

    ☐ No ☐ Yes, _____*(procedure)*
12. Is future surgery contemplated?

    ☐ No ☐ Yes, _____*(procedures)*
13. Has the patient undergone diagnostic tests for this condition?

    ☐ No ☐ Yes, please attach the results of the diagnostic tests.

14. What is the nature of the condition?

☐ New ☐ Aggravation of Existing ☐ Recurrence of Previous

15. Are the patient's description of the symptoms and circumstances of the condition consistent with the results of diagnostic tests or the clinical signs of your diagnosis?

☐ Yes ☐ No, please detail _____

16. Has the patient been unable to work due to this condition?

☐ No ☐ Yes, from _____/_____/_____ ***AND:***

☐ The patient returned to work on _____/_____/_____ ***OR***

☐ The patient is unfit for work and is anticipated to be able to resume (compulsory):

Partial duties on _____/_____/_____

Full duties on _____/_____/_____

17. Does the patient have any co-morbidity that will affect recovery from this condition?

☐ No ☐ Yes, _____

18. Is the condition likely to cause any permanent disability for this patient

☐ No ☐ Yes:

Type of Disability_____

Percentage Loss of Function _____(%)

19. Do you have any further information that may assist us to assess the condition of the patient?

☐ No ☐ Yes, _____

_____

Signature: _____Date: _____/____/__

Name *(please print):* _____

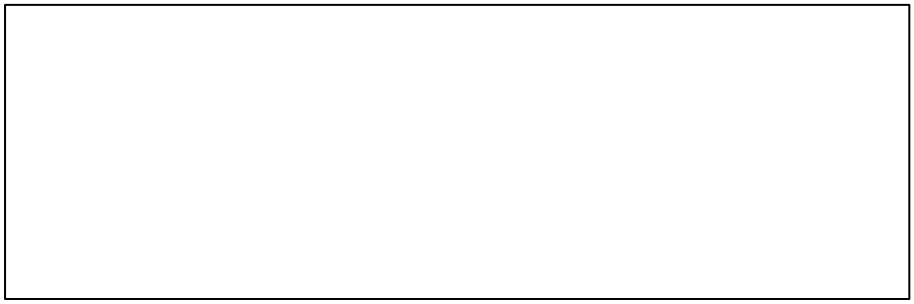
Qualifications: _____

Address _____

_____

Phone No: _____

Medical Practitioner's Stamp



Gallagher