Group Risk Claims
Preliminary Medical Attendant's Statement

June 2019

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Please note: If there is a fee for completion of this form it is the responsibility of your patient.

To assist with a quick determination of this claim it is essential that a treating doctor completes this form.

Please include copies of any investigation reports (including blood tests, x-ray and radiology reports) or treating specialist reports that support the diagnosis.

Please ensure all sections of this form are completed, as this information will be relied upon when considering your patient's claim. If you are unable to complete any section please indicate your reasons for this.

If there is insufficient space on this form, please use the space at the back of the form or attach a separate page. Please ensure that you identify the question to which the additional information relates.

Patient's full name

Patient's address (number and street)

Suburb/Town State Postcode

Date of birth (dd/mm/yyyy) / / Height Weight

1. Diagnosis

Primary

Secondary

2. Please state the objective findings which support the above diagnosis. Please attach copies of investigation reports and treating specialist reports.

3. Please list current symptoms and severity of condition.

4. Are the symptoms consistent with the diagnosed condition? ☐ Yes ☐ No

5. Is the severity of condition consistent with the pathology? ☐ Yes ☐ No

6. Are you the patient's regular doctor? ☐ Yes ☐ No

If **no**, who is? Please provide details.

7. Did you know the patient personally before they consulted you professionally? ☐ Yes ☐ No

8. On what date did the patient first attend you for any reason? (dd/mm/yyyy) / /

9. When did the patient first become aware of the claimed condition? ..... (dd/mm/yyyy) / /

10. When did this patient first consult you for the above condition? ..... (dd/mm/yyyy) / /

11. When was the condition first diagnosed? ..... (dd/mm/yyyy) / /

12. List all dates of consultation since.

13. What are the predisposing causal factors associated with the patient's condition?

14. So far as you are aware, how did the injury/illness arise? Please also provide the history your patient gave you at first consultation for the illness/injury.

15. Has the patient had the same or similar condition in the past? ..... ☐ Yes ☐ No

If **yes**, please provide details.

16. Please describe the treatment prescribed, including all medication and dosages, and the response to this treatment.

17. Please outline any proposed treatment to assist the patient's recovery and return to the workforce.

18. Has the patient been compliant with treatment? ..... ☐ Yes ☐ No

19. What evidence do you have that they are compliant? If non-compliant, please state reason why.

20. Have all treatment options been attempted? ..... ☐ Yes ☐ No

21. Has the condition stabilised? ..... ☐ Yes ☐ No

22. Prognosis:

Short term

Long term

23. Please complete the table below with the relevant details for all referrals to other doctors.

Doctor's name and speciality	Date first consulted (dd/mm/yyyy)	Date last consulted (dd/mm/yyyy)	Surgery address	Phone no.	Referred by	Reason for referral
	/ /	/ /				
	/ /	/ /				
	/ /	/ /				

24. Has the patient ever been hospitalised for this condition? ☐ Yes ☐ No

If **yes**, please provide details below. Please also enclose a copy of the hospital discharge summary.

Name and address of hospital	Date of admission (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)
	/ /	/ /
	/ /	/ /

25. From what date was the patient first certified by a medical practitioner to be totally unfit for work? / /

If you did not certify the patient please advise the medical practitioner's details.

26. From what date was the patient fit to return to the workforce? (dd/mm/yyyy) / /

27. Has the patient performed any work since that date? ☐ Yes ☐ No

If **yes**, please provide details.

28. Is this patient still totally unable to work in their pre-disability/usual occupation? ☐ Yes ☐ No

29. When do you anticipate the patient will be fit for full duties? (dd/mm/yyyy) / /

30. When do you anticipate the patient will be fit for partial/suitable/alternative duties? (dd/mm/yyyy) / /

31. What are your patient's occupational duties?

32. Please list the specific occupational duties the patient is able to perform.

33. Do you recommend the appointment of a rehabilitation specialist to assist the patient in returning to the workforce? ☐ Yes ☐ No

If **yes**, please outline your recommendations below. If **no**, please state your reasons for this below.

34. Please list the specific duties the patient is unable to perform and the reasons why they are prevented from performing these duties.

35. Please quantify the number of hours the patient is able to work per week.

36. Please state any specific restrictions due to the subject medical condition (i.e. exclude pre-existing restrictions).

Lifting below the waist	kgs	Sitting	mins	Kneeling	mins
Lifting at the waist	kgs	Walking	mins	Crawling	min/mtr
Lifting above shoulder	kgs	Standing	mins	Bending	mins
Carrying	kgs	Driving	mins	Climbing	☐ Yes ☐ No
Reaching above shoulders	kgs	Working at heights	☐ Yes ☐ No	Climbing	min/mtr

37. Are there any other restrictions (excluding pre-existing restrictions)?

38. If the patient's employment was a significant or contributing factor to the symptoms, please provide details.

39. Is the patient suffering from any other condition or are there any other factors which might in any way contribute, aggravate or impair their ability to return to work? ☐ Yes ☐ No

If **yes**, please provide details.

40. Have you, or are you, completing forms or reports for any other organisation (e.g. insurance company, credit provider, Workers' Compensation, Centrelink) or for sick leave? ☐ Yes ☐ No

If **yes**, please provide details.

41. Are you aware of the patient's full employment and educational history? ☐ Yes ☐ No

42. Do you believe the patient will ever return to gainful employment? ☐ Yes ☐ No

43. Please provide any additional information you believe would be beneficial to us when considering your patient's claim.

Please attach the following to this completed form. Please tick the box to confirm document is attached.

☐ Any specialist and other medical reports.

☐ Hospital discharge summary if appropriate (for hospital stays of more than three days).

☐ X-ray and other radiology reports, pathology and other test results.

☐ List of all consultations or copies of clinical notes since first consultation.

☐ Any other information that will assist with the assessment of this claim.

Please note due to court rulings, we may be required to provide this, or any other report you provide, to the Trustee, your patient, independent specialist and relevant industry body.

Declaration

I declare that the above details are true and correct.

Your name			
Qualifications			
Surgery address (number and street)			
Suburb/Town			
Phone		Fax	
Email			
Signature	✗	Date (dd/mm/yyyy)	/ /

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