

# Continuing Disability Statement



**Claim Number:**

Dear Doctor,

Your Patient has submitted a claim under an accident and sickness policy with us. In order to receive benefits, your Patient must objectively demonstrate incapacity to attend to the core components of their normal occupation.

In order for us to determine our liability for this claim and/or on-going benefits, we need to establish the precise nature and extent of your Patient's health concerns. Therefore your assistance in completing this form would be greatly appreciated in providing the necessary objective evidence of incapacity and the outcome expectations.

Thank You.

This form should be completed in FULL.

**Please note that your Patient is responsible for any fee for or associated with the provision of this Statement.**

Please answer ALL relevant questions concerning your Patient and tick (✓) boxes where applicable.

**1. Patient Details:**

- (i) Patient's Name: .....
- (ii) Date of Birth:..... Height (cm)..... Weight (kg).....

**2. Please describe the precise nature and extent of your Patient's primary health concern?**

.....  
.....  
.....

- (i) Has a diagnosis been reached?  Yes or  No
- (ii) Please give details:

.....  
.....  
.....

**3.**

- (i) When were you first consulted for your Patient's condition? .....
- (ii) Please provide details of subsequent consultations with you or one of your colleagues at the practice:

.....  
.....  
.....

**4.**

- (i) Please outline the treatment(s) provided to date:

.....  
.....  
.....

- (ii) Please describe your Patient's response to this:

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**5.**

(i) Please indicate whether you consider your Patient to be TOTALLY or PARTIALLY incapacitated:

.....  
 .....  
 .....

(ii) If TOTALLY incapacitated, please identify the activities of your Patient's normal occupation that he/she is unable to presently perform:

.....  
 .....  
 .....

(iii) If PARTIALLY incapacitated, do you endorse your Patient being able to return to work in a limited / supported capacity at this time?  Yes or  No

If No, when might this be achievable from a clinical standpoint?

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 .....  
 .....

**6.** Have you referred or do you intend to refer your Patient to specialist management?  Yes or  No

If Yes, please give details of whom and dates of referral:

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 .....  
 .....

**7.** Please outline your outcome expectations/prognosis and include a realistic timeframe for return to PARTIAL or FULL duties:

.....  
 .....  
 .....

Partial duties: ..... Full Duties: .....

**8.** Are you aware of any factors that are delaying or could delay your Patient's anticipated recovery? Please give details:

.....  
 .....

**9. Doctor's Details**

(i) Name: .....

(ii) Qualification: .....

(iii) Phone Number: ..... Fax Number: ..... Email: .....

(iv) Address: .....

(v) Signature: ..... Date: .....