QBE INSURANCE (AUSTRALIA) LIMITED
ABN 78 003 191 035

Attending Physician's Statement

Any charge for this statement must be borne by the patient.
Please complete all sections.

Policy Number			Claim Number	

Patient's Details

Patient's Name (Block Letters)	Surname			Given Name(s)			
Address							
				State		Postcode	
Date of Birth	/ /	Height	cm	Weight	kgs	Sex Male ☐	Female ☐
Occupation							

History

When did the patient first receive medical treatment?	Date	/ /
Was there a previous history of this or a similar condition?	No ☐ Yes ☐ – advise when treatment was given	

Condition

Please give a complete diagnosis of this condition.

If Injury

When did the patient suffer the injury?	Date	/ /	Time	am/pm
What did the patient tell you were the circumstances surrounding the injury?				

If Illness

When was the illness first contracted?	Date	/ /	Time	am/pm
When did the symptoms become evident?	Date	/ /	Time	am/pm

Degree of Disability

When was the patient obliged to cease work?	Date	/ /	Time	am/pm
If the patient is still disabled, when will the patient be able to resume:				
• one or more of the material tasks of his/her occupation?			Date	/ /
• all of the tasks of his/her occupation?			Date	/ /
If the patient has recovered, when was the patient able to resume:				
• one or more of the material tasks of his/her occupation?			Date	/ /
• all of the tasks of his/her occupation?			Date	/ /

A FINAL MEDICAL CERTIFICATE IS REQUIRED SHOWING THE ACTUAL DATE THE PATIENT HAS RESUMED WORK.

Treatment of Present Condition

When were you first consulted? Date	/ /
When were you last consulted? Date	/ /
How often has the patient consulted you?	Times
Was the patient confined to hospital?	No ☐ Yes ☐ – give details

Name of Hospital	Address	Period of confinement	
		From	To
		/ /	/ /
		/ /	/ /

What are the current subjective symptoms?

Please give results of any objective findings

X Rays	
Other Tests	

What surgical procedures have been performed or are being contemplated?

Is there any underlying condition affecting recovery from the current condition? No ☐ Yes ☐ – advise nature of underlying condition and how it affects disability and recovery.

Please advise names and addresses of other treating physicians.

Do you believe rehabilitation would benefit this patient? No ☐ Yes ☐

Have you terminated treatment? No ☐ Yes ☐ – advise date / /

What is the current prognosis?

Are there any further remarks which may assist in assessing this condition?

Doctor's Name		Qualifications			
Address					
		State		Postcode	
Telephone No.	( )				
Signature	X	Date	/ /		

This Policy is underwritten by QBE Insurance (Australia) Limited ABN 78 003 191 035 of 82 Pitt Street, Sydney.