Medical Attendant's Statement

Forming part of the Salary Continuance Insurance/ Income Protection Member Initial Claim Form

To be completed by the doctor or medical provider you have mainly consulted for this disability.
If there is a charge for completing this form, the payment is the responsibility of the patient.

Privacy
In completing this form you may be providing AIA Australia Limited with personal and sensitive information. This information must be handled, collected, used and disclosed in accordance with the Privacy Act 1988 (Cth) and the AIA Australia Group Privacy Policy as updated from time to time (AIA Australia Privacy Policy). For more information about the AIA Australia Privacy Policy (including notification) please refer to www.aia.com.au or contact 1800 333 613 to request a copy. AIA Australia may, if requested by the patient, require that you consider a request for personal and sensitive information and act accordingly.

Fund Name _____ Fund Member No. _____

Patient's Name _____ Date of Birth / /

Patient's Address _____ Postcode

Occupation _____

Patient's height _____ cm weight _____ kg Is your patient left or right handed? ☐ Left handed ☐ Right handed

Does your patient smoke? ☐ Yes ☐ No If '**Yes**', please state substance, quantity and how long they have smoked.

_____

1. How long have you known this patient? Professionally _____ Personally _____

2. (a) Are you the patient's usual doctor? ☐ Yes ☐ No
If '**No**', please advise the name, address and telephone contact details of their usual doctor.

Name of usual doctor _____ Telephone _____

Address _____

(b) If the patient was referred to you, please advise name, address and contact number of referring doctor.

Name of referring doctor _____ Telephone _____

Address _____

3. (a) Please confirm whether the condition is an injury or sickness. ☐ Injury ☐ Sickness

(b) Please describe the nature and extent of the patient's condition, its probable cause (if known) and the level of disability.

_____

(c) Is the injury/sickness consistent with the patient's description of cause? ☐ Yes ☐ No If '**No**', please provide details.

_____

4. (a) (i) On what date did the condition first occur? Date / / Time _____ am/pm

(ii) **Please advise the date that total disablement commenced and caused the patient to become unfit for work.** / /

(iii) Is the patient still receiving treatment? ☐ Yes ☐ No

(b) When were you first consulted for this condition? / /

(c) Please provide details of all subsequent consultations.

5. Are there any factors affecting or prolonging the condition? For example, does the patient have any contributing, concurrent or pre-existing conditions. ☐ Yes ☐ No If '**Yes**', please provide details.

6. If any tests or investigations have been performed (i.e. x-ray, CT Scans, MRI, blood tests, etc.) please provide results (or attach a copy of applicable reports if available).

7. (a) (i) What is the diagnosis and what are the objective clinical signs of the condition?

(ii) Date of diagnosis. / /

(b) What is your short term and long term prognosis?

(c) Please describe your patient's current symptoms.

(d) (i) Is your patient's illness considered terminal? ☐ Yes ☐ No

(ii) If '**Yes**', what is the patient's life expectancy? months

(e) Has the patient suffered from this or a similar condition previously? ☐ Yes ☐ No If '**Yes**', please provide the following:

(i) date of previous injury/sickness / / (ii) period of disability

(iii) date of diagnosis / / (iv) prognosis

(f) Has the patient been referred to any other doctor/s, or medical provider/s, or rehabilitation provider/s or other health professionals for treatment or consultation? ☐ Yes ☐ No If '**Yes**', please state:

Date of referral	Name and field of practice (eg. oncologist, cardiologist, etc.)	Address and telephone contact details
/ /		Tel:
/ /		Tel:
/ /		Tel:

8. What is the current treatment plan (including names and dosages of any medication/s)?

9. (a) To the best of your knowledge is the patient following the treatment plan prescribed? ☐ Yes ☐ No If '**No**', please comment.

(b) Do you consider any other treatment plan necessary and/or beneficial for recovery and return to work in their usual capacity? ☐ Yes ☐ No If '**Yes**', please comment.

(c) Has the patient been involved in any other medical, surgical, rehabilitation or other treatment you have scheduled? ☐ Yes ☐ No
If '**Yes**', please provide full details.
If '**No**', would the patient benefit from such a program, including Occupational Rehabilitation, eg. graduated RTW program, studying, re-training, etc.?

10. Was the patient hospitalised? ☐ Yes ☐ No If '**Yes**', please provide details below (attach a separate sheet if required).

Date admitted	Date discharged	Hospital name/Address and telephone contact details	Condition/Procedure
/ /	/ /	Tel:	
/ /	/ /	Tel:	
/ /	/ /	Tel:	

11. Have you given any other certificates concerning the patient's disability? ☐ Yes ☐ No If '**Yes**', please provide details.

12. (a) To the best of your knowledge, what are the duties of the patient's usual occupation?

(b) Does your patient work ☐ Full-time ☐ Part-time ☐ Casual ☐ Contractor

(c) Please state the duties and/or responsibilities the patient is **unable** to perform of their usual occupation, including the reasons why they are **unable** to perform them.

Work duty **unable** to perform	Reason they are **unable** to perform this duty

(d) How long do you expect the patient to be **unable** to perform these duties? From / / to / /

(e) Is the patient **able** to perform any of their **usual** occupational duties? ☐ Yes ☐ No
If '**No**', please go to question 12(f)
If '**Yes**', please enter the date the patient returned to work (or will be able to return to work): / /
Please provide full details including which duties the patient **can perform** and the number of hours per week these duties can be performed. (After detailing the duties below please go to question 13.)

Duties	No. of hours duties can be performed

(f) Is the patient **currently performing** any **alternative** duties? ☐ Yes ☐ No If '**No**', please go to question 12(g)

If '**Yes**', please state: From / / to / /

Please provide full details including which duties the patient is **currently performing** and the number of hours per week these duties can be performed.

Duties	No. of hours duties can be performed

(g) If still **unable** to work, when do you expect that your patient will be:

(i) **able** to perform **some** of the duties of their **usual** occupation? / /

(ii) **able** to perform **all** of the duties of their **usual** occupation? / /

(h) Will the patient be able to perform any work/duties within their education/training or experience in the future? ☐ Yes ☐ No
Please give details.

ADDITIONAL INFORMATION

13. Please provide any additional information or comments you feel are relevant to this claim.

DECLARATION

I hereby certify that I have personally attended the above named patient and that all the information supplied by me on this form is true, correct and complete.
I confirm that I have handled, collected, used and disclosed the patient's personal and sensitive information provided with this form in accordance with privacy law.
I understand that AIA Australia may be entitled or required to provide access or a copy of my report to the patient, the patient's representatives, a conciliator, mediator, tribunal or court, or to medical specialists and other third parties, under privacy law and the AIA Australia Group Privacy Policy, and authorise AIA Australia to do so.

Name *(please print)* Qualification(s)

Signature Date

Address Postcode

E-mail

Telephone Facsimile