Doctor's Certificate (For Critical Illness Claims)

Personal Details

Name of the patient: _____

Father / Spouse's Name _____

Age: _____ Gender: ☐ Male ☐ Female

_____

City _____ State _____ Country _____PIN Code: _____

Hospital Details

Outpatient/In-patient No: _____ (If In Patient) From _____ to _____

Hospital Name: _____

Name of Critical Illness *(As per the product)*

☐ Heart Attack	☐ Cancer	☐ Coma	☐ Angioplasty	☐ Cardiomyopathy	☐ Paralysis	☐ Deafness
☐ Surgery to Aorta	☐ Multiple Sclerosis	☐ Loss of Speech	☐ Alzheimer's Disease	☐ Loss of Limbs		
☐ CABG (Coronary Artery Bypass Surgery)	☐ Apallic Syndrome	☐ Benign Brain Tumor	☐ End Stage Liver Disease			
☐ Major Head Trauma	☐ Aplastic Anaemia	☐ Parkinson's Disease	☐ Primary Pulmonary Hypertension			
☐ Motor Neuron Disease	☐ Kidney Failure	☐ Major Burns	☐ Chronic Lung Disease	☐ Stroke	☐ Blindness	
☐ Brain Surgery	☐ Major Organ Transplant	☐ Heart Valve Surgery	☐ SLE with Lupus Nephritis	☐ Poliomyelitis		
☐ Muscular Dystrophy	☐ Medullary Cystic Disease	☐ Loss of Independent Existence	☐ Terminal Illness			

Note: *Kindly fill additional Doctor's Certificate available for Paralysis, Parkinsons Disease, Stroke, Muscular Dystrophy, Major Head Trauma, and Doctor's Certificate for Neurological condition for Alzheimer's Disease, Deafness, Multiple Sclerosis, Loss of Speech, Loss of Limbs, Motor Neuron Disease, Blindness, Loss of Independent Existence*

Nature of Habits

☐ Smoking ☐ Alcohol ☐ Tobacco ☐ Drugs i f yes, duration of consumption _____

Quantity consumed _____ Others (Please Specify) _____

Diagnosis & Treatment

Date of First Consultation/diagnosis: _____

What were the symptoms / illness / disease? _____

Which investigations / tests were performed: _____

Duration of symptoms / Illness / Disease: _____

Diagnosis made and Informed to the patient: _____

Interval between onset and diagnosis: _____ Years _____ Months _____Days

Antecedent conditions related or contributing but not related to the Illness: _____

_____

Are you aware if patient consulted any other doctor / hospital apart from you? (If yes, details thereof) ☐ Yes ☐ No _____

_____

Was the patient referred to you by any other doctor? If "Yes", please provide the details: ☐ Yes ☐ No _____

_____

Medical History

Have you ever treated the deceased during last 5 years, prior to final illness? ☐ Yes ☐ No If Yes;

Details of consultation in last 5 years	1	2	3	4	5
Date of consultation					
Patient presented with complaints of					

Name of Investigations/tests prescribed					
Dates on which the tests were done and the results					
Name and address of the laboratory where the tests were done					
Treatment / Medication given					

Declaration

The above statements are true and complete to the best of my knowledge and belief and as per the records maintained by me/hospital/clinic:

Name of the Doctor		**Signature of the Doctor**	**Doctor/Hospital seal**
Qualification of the Doctor			
Regd. no. of the Doctor			
Contact no. of the Doctor			
Email id of the Doctor			
Date			