pnb MetLife
Milkar life aage badhaein

Doctor's Certificate (For Death Claims)

Personal Details

Name of the deceased patient: _____

Father / Spouse's Name: _____

Age: _____ Gender: ☐ Male ☐ Female

Address: _____

_____

City _____State _____ Country _____PIN Code:_____

Death Details

Outpatient/In-patient no: _____ Date of death: D D M M Y Y Y Y Time of death:_____

Place of Death: ☐ Home ☐ Hospital ☐ Office ☐ Other (please Specify Others / Hospital name and address)

_____

Cause of Death: _____

Nature of Illness & Habits

☐ Hypertension ☐ Diabetes ☐ Lungs Disease ☐ Heart related aliments ☐ Malignancy ☐ Kidney disease

☐ Liver disease ☐ Others (Pls specify)_____

☐ Smoking ☐ Alcohol ☐ Tobacco ☐ Drugs if yes, duration of consumption _____ Quantity consumed

_____

Date of First Consultation/diagnosis: _____Information to the Patient_____

Diagnosis & Treatment

Duration of symptoms / Illness / Disease:_____

Which investigations / tests were performed:_____

_____

Interval between onset and death:_____Yrs _____ Months _____ Days

Antecedent conditions related or contributing but not related to the cause of death: _____

_____

_____

Are you aware if deceased consulted any other doctor / hospital apart from you? (If yes, details thereof)_____

_____

If death was due to unnatural reasons, please specify and provide death summary: _____

_____

_____

Inquest held: ☐ Yes ☐ No Autopsy / Postmortem done: ☐ Yes ☐ No

Was the deceased referred to you by any other doctor? If "Yes", please provide the details: _____

_____

Medical History

Have you ever treated the deceased during last 5 years ? ☐ Yes ☐ No If Yes

Details of consultation in last 5 years	1	2	3	4	5
Date of consultation					
What were the symptoms/ illness/disease					
Patient having this complaint since					
Name of the tests advised by you					
Dates on which the tests were done and the results					
Name and address of the laboratory where the tests were done					
Diagnosis made and informed to the patient					
Treatment / Medication given by you					

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			