5th Pillar
Family Takaful Limited
آئیے، ساتھ چلیں

MEDICAL ATTENDANT'S STATEMENT
OTHER THAN DEATH CLAIM FORM

Instructions:

1. This form may be completed by medical attendant who have treated the claimant covered in his/her -last illness.
2. Separate forms may be used for each attendant if more than one physician has attended during last illness of the claimant. However only one form is required for all contracts where the claimant was covered.
3. Please complete the form completely with legible handwriting avoiding cutting / overwriting.
4. This form should be duly attested by notary public, Nazim of a union council or above, executive of 5th Piller Family Takaful Limited or class I officer of the federal/provincial government.

Membership No(s)			

Information about the Member

a)Name:	b) Date Of Birth	c)Gender ☐Male ☐Female
d)d. Marital status (S/D/W/O):	e)CNIC No.	
f) Residential Address:	g)Occupation:	

Medical History

a) Date symptoms first appeared or accident occurred	b) Date patient ceased to work because of incapacity
c) Has patient ever had the same or similar conditions? ☐Yes ☐No ☐Dont Know	d) If yes, please state when and describe:
e) Is illness, injury due to the patient's employment? ☐Yes ☐No ☐Dont Know	f) If diagnosis is pregnancy, give expected date of delivery: DD / MM / YYYY
g) Please provide name(s) and specialty(ies) of other treating physicians:	h) Patient's current height: / i) Patient's current weight:
j) Primary diagnosis:	k) Additional conditions or complications:
l) Subjective symptoms (including severity and frequency):	
m) Findings (please enclose a copy of current X-ray, ECGs, laboratory findings, and any clinical findings):	

Physical Capacity

Describe functional capabilities, specifying continuous length of time of weight borne while:

☐Sitting	☐Standing	☐Walking	☐Lifting	☐Carrying	☐Bending

Treatment Dates

a) Date of first visit for current condition:	b) Date of most recent visit:	c) Frequency of visits:
DD / MM / YYYY	DD / MM / YYYY	☐Weekly ☐Monthly ☐Other (specify)

Nature of Treatment

a) Medications (including prescribed dosages):	b) Surgeries (completed or anticipated):
c) Other:	d) Is patient following recommended treatment? ☐ Yes ☐ No (please elaborate

Confinement to Hospital (If Applicable)

Name of Hospital	Date From	Date To	Treatment Provided

Progress

Has patient	☐ Recovered?	☐ Improved?	☐ Not improved?	☐ Retrogressed?

Restrictions

What precisely is preventing your patient from returning to work?

Prognosis

Prognosis for medical recovery:

Other factors affecting recovery:

Remarks

Please provide any comments or pertinent details that you think would be helpful in adjudicating your patient's claim:

Witness	Attending Physician
Signature & Date:	Signature & Date:
Name:	Name:
Address:	Address: