Medical Attendant's Statement

To be completed by the attending Medical Practitioner.

Important: please make sure you've answered all questions.
Use BLOCK letters and dark ink when completing this form and ensure that it is signed and dated.

Please read the below prior to completing this statement.

The patient has applied to AIA Australia for payment of an insurance benefit.

From your professional association with your patient, please complete in detail the following questions in relation to any illness or medical impairment, which in your opinion might affect his/her capacity.

Patient must return the completed form to AIA Australia at au.retail.claims@aia.com

If there's a charge for completion of this statement, it 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 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.

Medical Attendant's Statement

1. What is the patient's name and date of birth?

Name:

Date of birth (dd/mm/yyyy): / /

2. How long have you known the patient and how long have they attended your practice?

Known patient:

Attended practice:

3. Does the patient currently smoke tobacco or have they ever smoked tobacco? ☐ No ☐ Yes

If '**Yes**', please provide further details such as date commenced and/or date ceased, current daily quantity, etc:

4. What is the primary/secondary condition?

Primary condition details:

Primary condition date of diagnosis (dd/mm/yyyy): / /

Secondary condition details, and any additional medical conditions (if applicable):

Secondary condition date of diagnosis (if applicable) (dd/mm/yyyy): / /

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5. What is the nature and severity of the symptoms your patient is currently reporting?

Symptoms:

Severity:

6. When did these symptoms first arise? (dd/mm/yyyy): / /

7. What is the long-term / short-term prognosis?

8. If Illness, is your patient considered terminal? ☐ No ☐ Yes

If '**Yes**', what is the life expectancy?

9. Has the patient ever suffered a similar or the same condition in the past? ☐ No ☐ Yes

If '**Yes**', please provide further details:

10. What was the first / last consultation date and frequency of consultations with respect to the claimed condition?

First consult date: / /

Last consult date: / /

Frequency of consults (weekly, fortnightly, monthly/or as needed):

11. Please provide details as listed below for investigations, treatments, medications and referrals:
Investigations, treatments, medications (including dosages) and referrals undertaken to date:

Please provide details as listed below for investigations, treatments, medications and referrals:
Investigations, treatments, medications (including dosages) and referrals planned for future date:

12. Please provide details of any hospitalisation and/or surgical interventions relating to the claimed condition.

13. Please provide details of any rehabilitation that has been undertaken by, is planned, or otherwise suitable for the patient to assist with their recovery and return to work.

14. What do you understand to be the patient's duties they undertake?

15. On what consultation date(s) did you first note that the patient was not capable of performing (a) all and/or (b) some of their duties?

(a) All of their duties / / (b) Some of their duties / /

Which of their duties was the patient not capable of performing?

Please complete this section if the patient is suffering from a physical condition. If it is a psychological condition, please go to the psychological function section. If both apply, please complete both functional sections.

16. Please detail the patient's functional ability below. Please consider **ALL** functions and not only those related to the patient's occupation:

Ability	**Maximum functional ability**					
Sitting	☐ Over 2 hours *Unrestricted with usual breaks*	☐ 2 hours *Able to sit for a dinner at a restaurant or to watch a full-length movie*	☐ 60 minutes *Able to watch the nightly TV news or one half of a sporting match on TV*	☐ 30 minutes *Able to sit as passenger for a 15km car trip with traffic*	☐ 10 minutes *Need to stand and change posture each advert break when watching TV*	☐ Nil *Unable to sit*
	Is this a current requirement of their role? ☐ Yes ☐ No ☐ Unsure					
	Additional comments:					
Standing	☐ Over 2 hours *Unrestricted with usual breaks*	☐ 2 hours *Able to stand to watch a music concert*	☐ 60 minutes *Able to stand to watch a sporting match*	☐ 30 minutes *Able to stand in the kitchen to prepare a meal*	☐ 10 minutes *Unable to stand to wait for a bus or train or wash up dishes in a sink*	☐ Nil *Unable to stand*
	Is this a current requirement of their role? ☐ Yes ☐ No ☐ Unsure					
	Additional comments:					

Ability	Maximum functional ability					
Walking	☐ Over 2 hours *Unrestricted with usual breaks*	☐ 2 hours *Able to walk around a shopping mall, visiting various shops*	☐ 60 minutes *Able to walk around an art gallery or museum*	☐ 30 minutes *Able to walk around a supermarket to perform a weekly shop*	☐ 10 minutes *Unable to walk around two standard blocks (600 m)*	☐ Nil *Unable to walk*
	Is this a current requirement of their role? ☐ Yes ☐ No ☐ Unsure					
	Additional comments (including whether the patient can walk on uneven surfaces):					
Lifting	☐ 18–25 kg *Able to lift a bag of cement*	☐ 13–17 kg *Able to lift an 18-month-old child*	☐ 8–12 kg *Able to lift a vacuum cleaner or one case of 24 cans of drink*	☐ 4–7 kg *Able to carry a full (dry) washing basket, or 2–3 shopping bags*	☐ 1–3 kg *Unable to lift a laptop computer*	☐ Nil *Unable to lift a 1 L milk or soft drink bottle (1 kg)*
	Is this a current requirement of their role? ☐ Yes ☐ No ☐ Unsure					
	Additional comments:					
Driving	☐ Over 2 hours *Unrestricted with usual breaks*	☐ 2 hours *Able to drive long freeway distances with appropriate safety breaks*	☐ 60 minutes *Able to drive for 30 km, across city suburbs or between country towns*	☐ 30 minutes *Able to drive for 15 km car trip with traffic*	☐ 10 minutes *Unable to drive to local shops or local school run*	☐ Nil *Unable to drive*
	Is this a current requirement of their role? ☐ Yes ☐ No ☐ Unsure					
	Additional comments:					

Ability	Functional ability	**Comments:** (e.g. frequency in work day, expected duration of temporary work restriction with usual posture breaks)
Pushing/ Pulling	☐ kg	
Reaching above shoulders	☐ Yes ☐ No	
Bending from waist	☐ Yes ☐ No	
Kneeling	☐ Yes ☐ No	
Squatting	☐ Yes ☐ No	
Climbing stairs	☐ Yes ☐ No	
Typing	☐ Hours ☐ Minutes	

Please complete the following section if the patient has a psychological condition.

Psychological function	Is this psychological function impacted by the patient's condition(s)?	If 'Yes', please describe the impact.
Concentration	☐ Yes ☐ No	
Memory	☐ Yes ☐ No	
Energy	☐ Yes ☐ No	
Sleep	☐ Yes ☐ No	
Social interaction	☐ Yes ☐ No	
Motivation	☐ Yes ☐ No	
Panic attacks	☐ Yes ☐ No	
Mood	☐ Yes ☐ No	
Self-care	☐ Yes ☐ No	
Leaving the house	☐ Yes ☐ No	
Emotional control/ self-regulation	☐ Yes ☐ No	
Stress management	☐ Yes ☐ No	

Please provide details of any other functional restrictions or considerations not reflected above (if appropriate):

17. Has the patient returned to work in any capacity? ☐ No ☐ Yes

If **'No'**, in your opinion, when will they potentially be able to perform:

(i) Some duties of their occupation (dd/mm/yyyy)?

/ /

AND/OR

(ii) All duties of their occupation (dd/mm/yyyy)?

/ /

OR

(iii) ☐ Unsure/Unknown

OR

(iv) ☐ The patient will not be able to perform the duties of their occupation in the future.

If (iv) is selected, please provide further information below:

Why won't the patient be able to perform some or all of the duties of their usual occupation?

Will the patient be able to perform any work or duties within their education and/or training or experience in the future? Please provide rationale for response.

If '**Yes**', please answer the relevant following questions:

(i) On what date did they return to full hours and duties? (dd/mm/yyyy)

/ /

(ii) On what date did they return to partial hours and duties? (dd/mm/yyyy)

/ /

(iii) If returned to partial duties, please explain the nature of any return-to-work modifications and plans for future increases in hours or duties if known (as applicable):

18. Other than the medical factors, are there any psychosocial and environmental problems impacting the patient's ability to recover?

19. Does the patient have any other claims regarding this disability including but not limited to: Workers' Compensation, other insurance claims, Centrelink, etc? ☐ No ☐ Yes

If '**Yes**', please provide details including provider and claim number, if applicable:

20. Are there any additional comments or remarks that you would like to make?

Please include any supplementary reports (including Mini Mental Health Exams, if possible), diagnostics and certifications relevant to the claim condition.

Declaration

Title:

Surname:

First name:

Business address:

Contact details:

Telephone:

Email:

Qualifications:

I hereby certify that I have examined the patient and that all statements made in this statement are correct in all aspects. I consent to the Superannuation Fund and its Insurer providing copies of this statement to any medical specialist from whom the Insurer seeks an independent report or to any other person deemed necessary to assist in the assessment of the patient's claim.

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 Privacy Policy, and authorise AIA Australia to do so.

Signature

✗

Date