attending physician supplementary statement of incapacity

Wesfarmers General Insurance Limited, ABN 24 000 036 279, AFS Licence No. 241461, trading as Lumley Insurance
Level 2, 99 Melbourne Street, South Brisbane, QLD 4101 or GPO Box 524 Brisbane, QLD 4001
Freecall 1300 651 654 Fax 07 3307 4880

CLAIM NUMBER

Dear Doctor,

Your Patient has submitted a claim under an accident and sickness policy with us. In order to receive benefit, your patient must objectively demonstrate incapacity to attend to the core components of their normal occupation.
In order for us to determine their liability for this claim and/or on-going benefits, we need to establish the precise nature and extent of your patient's health concerns. Therefore your assistance in completing this form would be greatly appreciated in providing the necessary objective evidence of incapacity and the outcome expectations.

Many Thanks.

This form should be completed in FULL and forwarded to:

Wesfarmers General Insurance Limited

Level 2, 99 Melbourne Street, South Brisbane, QLD 4101 or GPO Box 524 Brisbane, QLD 4001

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Please answer ALL relevant questions concerning the patient and tick (√) boxes where applicable

Patient's name

Date of Birth / /

Height (cm)

Weight (kg)

1. Please describe the precise nature and extent of your patient's primary health concern?

   Has a diagnosis been reached? Yes ☐ No ☐

   Please give details

2. a. When were you first consulted for this patient's condition? / /

   b. Please provide details of subsequent consultations with you or one of your colleagues at the practice

3. a. Please outline the treatment(s) provided to date

   b. Please describe your patient's response to this

AHCLM754 (01/10)

4. a. Please indicate whether you consider the patient to be TOTALLY or PARTIALLY incapacitated?

b. If TOTALLY incapacitated, please identify the activities of the patient's normal occupation the he/she is unable to presently perform

c. If PARTIALLY incapacitated, do you endorse your patient being able to return to work in a limited/supported capacity at this time?

Yes ☐ No ☐

If **No**, when might this be achievable from a clinical standpoint?

5. Have you referred or do you intend to refer your patient to specialist management? Yes ☐ No ☐

If **Yes**, please give details of whom and dates of referral

6. Please outline your outcome expectations/prognosis to include a realistic timeframe for a return to PARTIAL or FULL duties

Partial duties / / Full duties / /

7. Are you aware of any factors that are delaying or could delay your patient's anticipated recovery? *(Please give details)*

Name

Qualification

Phone no. Fax no. Email

Address

State Postcode

Signature Date *(dd/mm/yyyy)*

AHCLM754 (01/10)