MiWay.co.za Life

MiWayLife
Medical Attendant Form.

Certificate of Medical Attendant: Claim Department

The Life Assured _____ (Name)
Completion of this form is required in order to elicit any information concerning the Assured medical history prior to _____ and should be completed from the records of the medical attendant at that time, namely Dr. _____ practising at _____
I, the undersigned _____ a registered medical practitioner, certify to the following facts in respect of the late _____.
Full Name(s) _____ Born on _____
For which period was the deceased a patient of the practice? From _____ to _____

Please detail the nature of any complaints for which the Life Assured consulted the practice:

Date	Presenting Symptoms	Diagnosis	Treatment given / prescribed

Was the deceased ever hospitalized or admitted to any institution?

Duration of Stay (from dd/mm/yy to dd/mm/yy)	**Reason or presenting** symptoms on admission	**Hospital or institution**	**Treatment Details** (including operations/ procedures performed)	**Final Diagnosis** (with result of any test / investigations done)

Please provide details of any other doctors or specialist consulted by the Life Assured:

(a) Dr. _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Address _

_ Postal Code _ _ _/_ _ _/_ _ _

Hospital/Clinic _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Date Attended _ _ _/_ _ _ /_ _ _

Telephone (work) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

(b) Dr. _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Address _

_ Postal Code _ _ _/_ _ _/_ _ _

Hospital/Clinic _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Date Attended _ _ _/_ _ _ /_ _ _

Telephone (work) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

(c) Dr. _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Address _

_ Postal Code _ _ _/_ _ _/_ _ _

Hospital/Clinic _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Date Attended _ _ _/_ _ _ /_ _ _

Telephone (work) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Did the Life Assured use alcohol or drugs in excess? Yes ☐ No ☐

Please provide full details: ____

____

____

Did the Life Assured smoke?	Yes	☐	No	☐
If yes, how many cigarettes:	Yes	☐	No	☐
And /or how many cigars?	Per day	☐	Per week	☐
And /or how many pipes of tobacco?	Per day	☐	Per week	☐

Was the patient advised to stop smoking? Yes ☐ No ☐

If so on what date: Date _ _ _ /_ _ _ /_ _ _

State Reason: _____

_____

_____

_____

The following information is required for record purposes:

Is there any reason to believe that the incident that resulted in this claim is in any way due to or arose?

Yes ☐ No ☐

Directly or indirectly, entirely or partially from AIDS or HIV infection?

If yes, give full details: _____

_____

_____

_____

If you know please state:

Date of Birth: _ _ _ /_ _ _ /_ _ _

Age at Claim: ____ Place of Incident: _____

Immediate cause of Claim (if known): _____

Date of commencement of illness:

_ _ _/_ _ _/_ _ _

Date when Life Assured first became aware of illness or any other symptoms:

_ _ _/_ _ _/_ _ _

Was an inquest or post mortem held? (if Death) Yes ☐ No ☐

If yes, where was it held and what were the findings? _____

_____

_____

Diseases or conditions which preceded or co-existed with the immediate cause of Incident:

Disease or Condition	Date Commenced	Date/s Consulted
	_ _ _/_ _ _/_ _ _	_ _ _/_ _ _/_ _ _ _ _ _/_ _ _/_ _ _
	_ _ _/_ _ _/_ _ _	_ _ _/_ _ _/_ _ _ _ _ _/_ _ _/_ _ _
	_ _ _/_ _ _/_ _ _	_ _ _/_ _ _/_ _ _ _ _ _/_ _ _/_ _ _
	_ _ _/_ _ _/_ _ _	_ _ _/_ _ _/_ _ _ _ _ _/_ _ _/_ _ _

Please provide details if any of the following condition influence or contributed to the cause:

Previous Illness or Injury: _____

Family History: _____

Habits: _____

Please provide full details of any other relevant facts: _____

_____

_____

_____

PLEASE PROVIDE IS WITH COPIES OF ANY REPORTS ON THE LIFE ASSURED, WHICH YOU MAY HAVE IN YOUR POSSESION.

Signed at _____ **this** _____ **day of** _____ **20** _____

Signature _____

Full name _____ **Address** _____

_____

Telephone No. ( ) _____ **Practice No.** _____