PAK-QATAR FAMILY TAKAFUL
Together for the Future

Physician's Statement – DS2 (Disability Claim Form)

Note : All answers must be in the physician's handwriting

Patient Information

Name of Patient: Fatima	Date of Birth: 05-06-1975
Patient's Address: 7-71/163, Mominabad Alamdar Road Quetta.	

Employer Information

Name of Employer: Fatima

1. History

(a) Date doctor first consulted due to disability: 07-06-2024.
(b) Date symptons first appeared or accident happened: 07-06-2024.
(c) Date patient ceased work because of disability: 07-06-2024.
(d) Has patient ever had same or similar condition? ☑ No ☐ Yes, state when and describe
(e) Is condition due to injury or sickness arising out of patient's employment? ☐ No ☑ Yes, state when and describe
(f) Name the first doctor with full address, consulted by the claimant for the above disability/accident?

Name of Doctor: DR SAMI RAZA — Mobile No: 03337823320
Address: SHAFAKHANA-E-SAHIB-UZAMAN HOSPITAL QUETTA.

2. Diagnosis BIMELLEOLAR FRACTURE (DISTAL TIBIA AND FIBULA) ANKLE (L).

(a) Date symptons first appeared or accident happened: 07-06-2024
(a) Diagnosis (including any complications): Fracture (L) Ankle.
(c) Subjective symptoms
(d) Objective findings (including current X-rays, ECG's, Labortory data any clinical findings):
(1) Clinical Findings: (L) Ankle was Swollen and deformed; Tender to touch.
(2) Diagnosis Studies and results:

3. Progress

(a) Patient is	☐ Ambulatory	☑ Bed Confined	☐ House Confined	☐ Hospital Confined	
(b) Patient has	☑ Recovered	☐ Improved	☐ Stabilized	☐ Retrogressed	

4. Prognosis

(a) Is the disability presumed to be reversable ☑ Yes ☐ No
(a) Is patient now capable of performing duties of ☑ Yes ☐ No
(c) What duties of his or her job is patient incapable of performing? She was unable to walk.
(d) Do you expect a fundamental or marked change in future? ☐ Yes ☑ No

If yes, patient should recover sufficiently to perform duties on or about DD-MM-YYYY
If No, Please explain: She has recovered as fracture has healed.

(e) Specify the date by which you presume that the patient will be able to resume his duties/work

☑ Totally ☐ Partially ☐ Temporarily ☐ Permanently

Remarks

Declaration: I hereby declared that the above statements are true and complete to the best of my knowledge.

Attending Physician's Name: DR SAMI RAZA
Address: SHAFAKHANA-E-SAHIB-UZAMAN
Speciality: ORTHOPAEDICSS
Telephone No:
Date: 09.10.2024
Signature:

DR. SAMI RAZA
Medical Superintendent
Shafakhana-e-Sahib-uz-Zaman
Quetta

PAK-QATAR FAMILY TAKAFUL LIMITED
102-105, Business Arcade, Block-6, P.E.C.H.S, Shahra-e-Faisal, Karachi 75400, Phone: (92-21) 34311747-56 (Ext-162)
Fax: (9221) 34386451, UAN: 021-111-TAKAFUL (825238), Email: life.claims@pakqatar.com.pk, www.pakqatar.com.pk