Pak-Qatar Family Takaful Limited

FAMILY TAKAFUL

Form DS-2

Physician's Statement

Note :
Please don't leave any blank, unanswered question, date and/or signature, wherever

Patient Information	Name of Patient: Ikhalid Wasim	Date of Birth: 25-03-1987
	Patient's Address: UC Pahar Ikhel village Wanda Ichanwaz	
Employer Information	Name of employer:	

1. History

(a) Date doctor first consulted due to disability: 01 (Day) 01 (Month) 2020 (Year)

(b) Date symptoms first appeared or accident happened: 31 (Day) 12 (Month) 2019 (Year)

(c) Date patient ceased work because of disability: 02 (Day) 01 (Month) 2020 (Year)

(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? ☑ Yes ☐ No ☐ Unknown

(f) Name the first doctor with full address, consulted by the claimant for the above disability/Accident?
Dr Akhter Ali (Name of Doctor) City Hospital (Address) 03348815630 (Mobile No.)

2. Diagnosis

(a) Date of Last examination/Consultation: 16 (Day) 1 (Month) 2020 (Year)

(b) Diagnosis (including any complications): Clavicle # (Right Side).

(c) Subjective symptoms: Pain at right shoulder.

(d) Objective findings (including **current** X-rays, ECG's, laboratory data and any **clinical findings**):
(1). Clinical Findings: Tenderness at right side of shoulder.
(2). Diagnostic studies and results: X-ray shows clavicle # (Right).

3. Progress

(b) Patient is ☐ Ambulatory ☑ Bed confined ☐ House confined ☐ Hospital confined

(a) Patient has ☐ Recovered ☐ Improved ☑ Stabilized ☐ Retrogressed

4. Prognosis

(a) Is the disability presumed to be reversible? ☐ Yes ☑ No

(b) Is patient now capable of performing duties of ☑ Yes ☐ No (His or Her Current Jon) ☐ Yes ☐ No (*Any other job for which he or she is reasonably suited or qualified by education, training or experience)

(c) What duties of his or her job is patient incapable of performing?

(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 ____ (Day) ____ (Month) ____ (Year)
If "No", please explain ____

(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.

Signature: Senior Medical Officer City Hospital Lakki Marwat	Date: 24-01-2020
Attending physician's name: Akhter Ali	Specialty: M.O.
Address: City Hospital	Telephone No.: 03348815630

Ref No.: GT/CL/2008/00054/1