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: Muhammad Irshad	Date of Birth: 10-07-1982
	Patient's Address: UC Piro Khel Landi Kotal District Khyber	
Employer Information	Name of employer: Chip Training & Consulting	

1. History

(a) Date doctor first consulted due to disability: 27-12-2020 (Day / Month / Year)

(b) Date symptoms first appeared or accident happened: 27-12-2020 (Day / Month / Year)

(c) Date patient ceased work because of disability: 28-12-2020 (Day / Month / 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 Zeeshan Khan Ortho A dept, hayat abad medical complex peshawar 091-9217140-46
(Name of Doctor / Address / Mobile No.)

2. Diagnosis

(a) Date of Last examination/Consultation: 28 Dec 2020 (Day / Month / Year)

(b) Diagnosis (including any complications): Femur Broken left leg History of fall

(c) Subjective symptoms

(d) Objective findings (including **current** X-rays, ECG's, laboratory data and any **clinical findings**):
(1). Clinical Findings

(2). Diagnostic studies and results: left shoft of femur fracture

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 with in 6 to 9 weeks

Remarks

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

Signature: [signature]	Date: 14-01-2021
Attending physician's name: Dr. Zeeshan Khan Ortho	Specialty: ortho surgeon
Address: Ortho A dept Hayat abad medical complex peshawar	Telephone No.: 091-9217140-46

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