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: Rizwana Minhaj	Date of Birth: 28-11-1982
	Patient's Address: UC 03 chakra Goth Korangi	
Employer Information	Name of employer: Rizwana	

1. History

(a) Date doctor first consulted due to disability: 17 (Day) 05 (Month) 2019 (Year)

(b) Date symptoms first appeared or accident happened: 17 (Day) 05 (Month) 2019 (Year)

(c) Date patient ceased work because of disability: 17 (Day) 05 (Month) 2019 (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?

Name of Doctor _____ Address _____ Mobile No. _____

2. Diagnosis

(a) Date of Last examination/Consultation: 26 (Day) - 06 (Month) - 2019 (Year).

(b) Diagnosis (including any complications): # First M.C. (LT)

(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:

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	Date 08-07-2019
Attending physician's name: Dr. Atique Ahmed	Specialty: Orthopaedic Surgeon
Address: AOMC Malabar / Malir	Telephone No. 0300-0655591.

DR. ATIQUE AHMED ... ORTHOPAEDIC ... KARACHI BOARD