YellowJersey

Claim reference number: _____
(For office use)

DOCTOR'S STATEMENT

to be completed by the attending doctor

Full name of patient: _____

Are you the patients usual Medical Attendant? YES / NO
Is the claimant's injury solely due to this accident? YES / NO

DETAILS OF THE ACCIDENT

Date of accident: ___/___/___

How did the accident occur?

Injuries sustained:

1. Were any dislocations sustained? YES / NO
2. Did the dislocation require reduction under anesthesia? YES / NO
3. Were any fractures sustained? YES / NO If yes, please confirm site of fracture(s):
4. Is any Physiotherapy required? YES / NO
5. Was there any damage to natural teeth requiring emergency dental treatment? YES / NO

If Yes to any of questions 1 – 5 above, please give further details:

Was an operation performed? YES / NO If yes, please give full details including date(s)

Is there any indication that alcohol was a contributory factor? YES / NO

For what period was the patient confined to hospital? Admitted: ___/___/___ Discharged ___/___/___

Has the accident resulted in any permanent facial scarring? If so is it between 3cm and 9cm or 10cm or longer?

Has the patient suffering any optical injury requiring an eye test or suffered damage to spectacles or contact lenses requiring repair or replacement?

Has the patient previously suffered from this type of injury? YES / NO If yes, please give full details:

Is the patient suffering from any other medical condition or disability that affects their recovery? YES / NO

If yes, please specify

1) Date treatment first sought: ___/___/___ 2) Date of last visit: ___/___/___ 3) Total number of visits: _____

Is the patient (please circle): RECOVERED IMPROVED UNIMPROVED RETROGRESSED

Doctors name: _____

Doctors Address: _____

_____

Post code: _____

Tel: _____

Email address: _____

PLEASE APPLY STAMP HERE

Doctors signature: _____

Please use stamp, date and sign here Date: ___/___/___