Sportscover Australia Pty Ltd
T: 03 8562 9100 F: 03 8562 9111
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ACN 006 637 903 ABN 43 006 637 903
AFS Licence Number 230914

Medical Report

PLEASE ENSURE THAT ALL QUESTIONS HAVE BEEN FULLY ANSWERED

PLEASE NOTE:
These questions are to be completed by the main Doctor, Physiotherapist, Osteopath, Hand Therapist, Dentist or Chiropractor.

The insured is responsible for the completion of this form and any charges incurred for its completion.

MEDICAL REPORT

Patient's Details

Name _____ _____
(Surname) *(Given Names)*

Address _____

_____ State _____ Postcode _____

Telephone (AH) _____ Telephone (BH) _____

What is disabling the patient? *(Please give a complete diagnosis of this condition)*

_____

History

1. When did the patient first receive medical treatment for this injury? _____
2. (a) Was there a previous history of this or similar condition? ○ **Yes** ◉ **No**
   (b) *If **Yes**, please state the condition and advise when previous treatment was given*
   _____
3. (a) How long have you known the patient? _____
   (b) Are you the claimant's regular practitioner? ○ **Yes** ◉ **No**
   (c) *If **No**, please advise who is* _____

Injury

1. When did the patient suffer the injury _____
2. What were the circumstances surrounding the injury?
   _____

Degree of Disability

1. Patient's Occupation _____
2. When was the patient obliged to cease work? _____
3. If patient is still disabled, when approximately will the patient resume:
   (a) Some duties? _____ (b) Full duties? _____
4. If patient has recovered, when was the patient able to resume:
   (a) Some duties? _____ (b) Full duties? _____

Treatment of present condition

1. When were you consulted? (a) Initially _____ (b) Most recently _____
2. How often has the patient consulted you? _____

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MEDICAL REPORT – continued…

3. Was the patient confined to hospital? ◉ **Yes** ○ **No**
4. *If **Yes**, please advise* (a) Name of hospital _____
   (b) Period of confinement from _____ to _____
5. Was confinement in a convalescent home necessary after hospitalisation ○ **Yes** ◉ **No**
   *If **Yes**, please give details* _____
6. What are the current subjective symptoms? _____
7. Please give results of any objective findings:
   (a) X-Rays, MRI's _____
   (b) Other tests
   (*please advise tests done and findings)* _____
8. What surgical procedures have been performed? _____
9. What surgical procedures have been contemplated? _____
10. Are there any underlying conditions affecting recovery from the current condition? ○ **Yes** ○ **No**
    *If **Yes**, could you advise the nature of underlying conditions and how they affect disability and recovery:*
    _____
11. Does the patient have any other physical or mental impairment? ○ **Yes** ○ **No**
    *If **Yes**, please describe* _____
12. Please advise names and addresses of other treating physicians
    Name
    Address
    Telephone _____
13. If you have terminated treatment, please advise date _____
14. What is the current prognosis? _____
15. Are there any further remarks which may assist in assessing this condition?
    _____
16. Is there any permanent disability at present? ○ **Yes** ○ **No**
    If Yes, please explain giving an estimated percentage loss of function
    _____

Physician's Details

Full Name _____
Qualifications _____
Street Address _____
Suburb _____ State _____ Postcode _____
Telephone _____ Email _____
Website _____

Signature _____ Date _____