

## ATTENDING PHYSICIAN'S STATEMENT – Neurological Exam Form

\* Instruction : To be accomplished by the attending neurologist

The person whose name appears below is insured with Pru Life Insurance Corporation of U.K. against the happening of certain contingent events associated with their health. A claim has been submitted in connection with their insurance policy. To enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

**Name of the Patient** (Last name, First name, Middle name)

**Date of Birth**



**Address**

# Street			
City/Province		Zip Code	
		Tel #	

**Date of Examination**

**Other Examinations Performed**

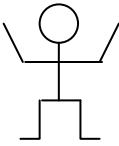
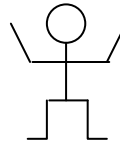
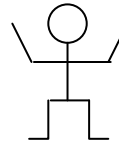
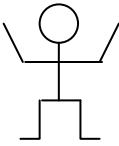
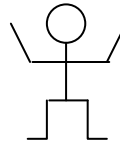
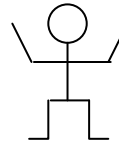
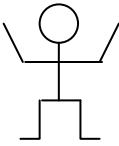
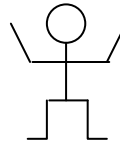
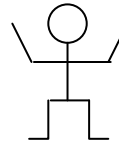


### A. General

Particulars	Please Describe in Detail
1. General behaviour and appearance of the patient	
2. Stream of talk	
3. Content of thought	
4. Mood and affect	
5. Intellectual capacity	
6. Sensorium	
7. Cranial nerves I II III, IV, VI V VII	VIII IX, X XI XII

**NAME OF PATIENT :** \_\_\_\_\_

Last Name, First Name, Middle Initial

8. Cerebellar			Babinski								
			Ankle Clonus								
<table style="width:100%; border:none;"> <tr> <td style="text-align:center; width:33%;">Motor</td> <td style="text-align:center; width:33%;">Sensory</td> <td style="text-align:center; width:33%;">DTR</td> <td></td> </tr> <tr> <td style="text-align:center;"></td> <td style="text-align:center;"></td> <td style="text-align:center;"></td> <td></td> </tr> </table>				Motor	Sensory	DTR					
Motor	Sensory	DTR									
											
9. How would you classify the disability ? Partial Permanent, Total Permanent, Partial Total Temporary or Partial Temporary?											
10. Duration of Illness/Disability. If duration for recovery is more than usual, please explain why.											
11. What is your prognosis?											
12. In your opinion, can the patient resume their usual occupation or employment?											
13. What is your final diagnosis?											

**DECLARATION**

I hereby certify that the answers and information given above are full, complete and true.

**AUTHORIZATION**

I further authorize the medical director of Pru Life Insurance Corporation of U.K. or any of its authorized representatives or other person in its employ, to obtain or secure from me or any clinic, hospital or entity all the medical records of the above-named patient. A photographic copy of this authorization is valid as the original.

**PURPOSE STATEMENT**

We will process the information you have provided in this form for the purpose of handling your patient's request in accordance with applicable privacy laws and regulations. During processing, we may share the information you provided to our authorized data processors, including couriers and contractors for anti-money laundering systems, photocopying, scanning, indexing and printing services. We may share any information provided with governmental and other regulatory authorities, or self-regulatory bodies in various jurisdictions as required or allowed by applicable laws and regulations. Any information collected may be retained by Pru Life UK and our authorized data processors until ten (10) years from the date of termination of the policy.

You may revisit our privacy policy through our website at (<https://www.prulifeuk.com.ph/en/footer/privacy-policy/>). For data privacy concerns, please contact our Data Privacy Officer at: Telephone: (632) 8887 5433 for Metro Manila, 1 800 10 7785465 via PLDT landline for domestic toll-free Email: [dpo@prulifeuk.com.ph](mailto:dpo@prulifeuk.com.ph)

\_\_\_\_\_  
Signature Over Printed Name of the  
Attending Physician

\_\_\_\_\_  
Specialization

License No:  
Address :

\_\_\_\_\_  
Date