PRU LIFE U.K.

ATTENDING PHYSICIAN'S STATEMENT – Neurological Exam Form

* Instruction : This form shall be accomplished by the attending neurologist on the injury sustained.

The person whose name appears below is insured with us against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with his/her 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	

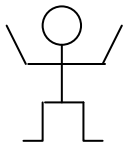
7. CRANIAL NERVES	
I	VIII
II	IX, X
III, IV, VI	XI
V	XII
VII	

NAME OF PATIENT : _____

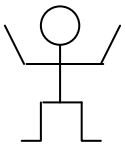
Last Name, First Name, Middle Initial

8. Cerebellar			Babinski
			Ankle Clonus

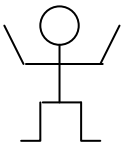
Motor



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. Prognosis	
12. In your opinion, can the patient resume his/her 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 your Medical Director or any of his/her authorized representative or other person in your 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.

_____
Signature Over Printed Name of the Attending Physician

_____
Specialization

License No:
Address :

_____
Date