

Sports injury attending physician's report

Important

1. The patient is responsible for any fee for this statement.
2. This form can only be completed by the treating medical practitioner, surgeon or physiotherapist.
3. If "Yes" answered to any of the following, please give details.
4. Dashes or blank spaces are not acceptable.

To be completed by the attending physician/physiotherapist

Patient's full name:

How long have you known the patient?

What date and where were you first consulted by the patient in connection with the present injury?

Patient's occupation:

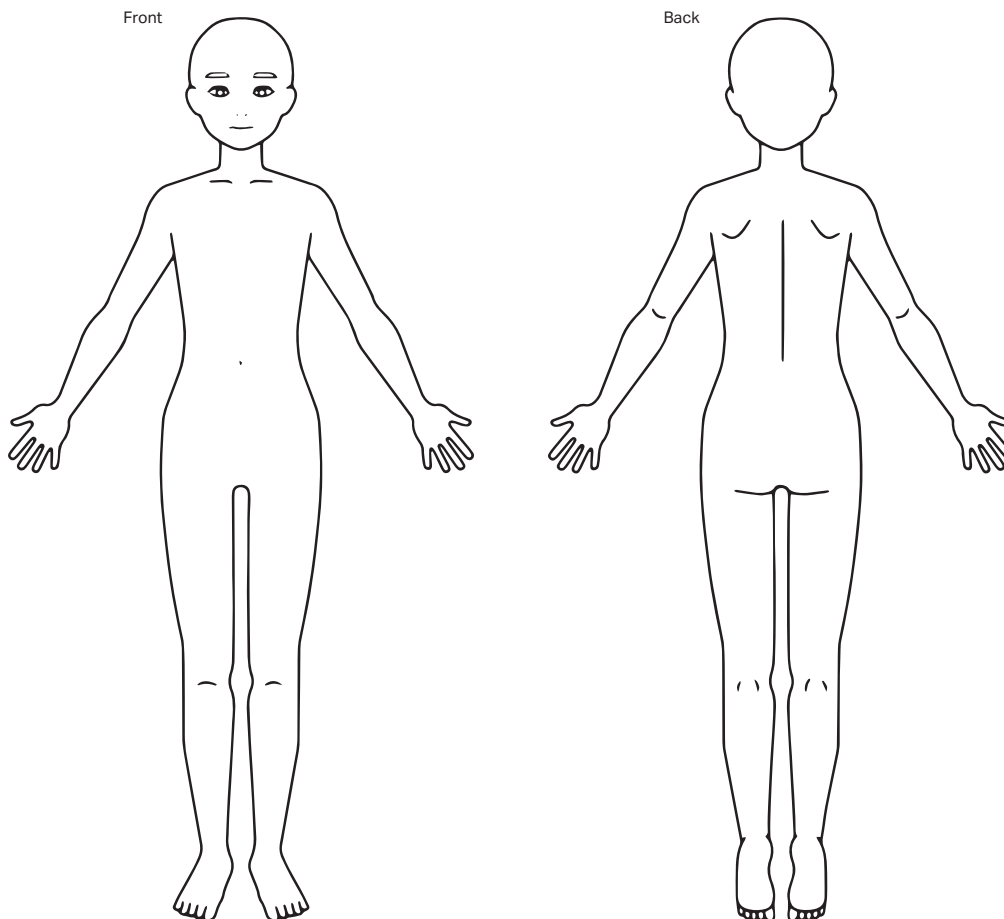
Are you the patient's regular general practitioner?

Yes

No

If not, please advise who is:

What is the exact nature of the present injury?



Do you consider the patient's injury to be a new injury?

Yes

No

A recurrence of an old injury?

Yes

No

If yes, please state condition and advise when previous treatment was given:

Have you referred the patient to any other services or treatment? Yes No

Please specify the type and approximate number of treatments required:

Physiotherapy

Chiropractic

Other

Have any surgical procedures been performed? If yes, please specify:

What surgical procedures are contemplated?

Are there any further remarks which may assist in assessing this condition?

Is there any permanent disability at present? Yes No

If yes, please explain giving estimated percentage loss of function:

Was the patient obliged to cease work? Yes No

If so, from when (date):

When do you expect the claimant to resume some duties (date): full duties (date):

What date do you advise the patient to return to netball? (date):

Does the patient have any congenital defects or chronic diseases? Yes No

If yes, please give dates, name of treating doctor and describe:

If the patient has been hospitalised, please give name of hospital and dates hospitalised:

Name of hospital: Date admitted Date released

Certification by attending physician

I hereby certify I have personally examined the above named patient and in my opinion the statements made in the Accident Details section of this claim form are consistent with the patient's injury.

Name: Telephone:

Fax: Email:

Address:

Signature: Qualifications:

Date: