Medical Statement General

To be completed by a registered medical practitioner.

Privacy - Use and disclosure of personal information

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The personal information you provide in the form is necessary for MetLife to provide your patient with the products and services they have requested from MetLife, and to manage their claim. You do not have to provide MetLife with this personal information, but if you do not do so MetLife may not be able to provide your patient with the products or services. MetLife complies with the Privacy Act 1988 and the principles laid out in its Privacy policy which details information about the entities that MetLife usually discloses personal information to (including overseas recipients), how you may access or seek correction of personal information, how we manage that information and our complaints process. MetLife's Privacy Policy is readily available and can be viewed at www.metlife.com.au/privacy.

Section 1. Medical practitioner details

Title	Given name(s)	Surname

Address

Suburb	State	Postcode

Phone number	Qualifications

Signature	Date *(dd/mm/yyyy)*
▶	

Section 2. Patient/claimant details

Title	Given name(s)

Surname	Date of birth *(dd/mm/yyyy)*

Section 3. Patient history

1. Are you the patient's usual doctor? ☐ Yes ☐ No	If Yes, how long have you known the patient?

2. When did the patient first consult you for the present condition (*dd/mm/yyyy*)?	/ /
3. When did the present condition commence (*dd/mm/yyyy*)?	/ /
4. From what date do you believe the patients condition to have prevented your patient from working (*dd/mm/yyyy*)?	/ /
5. Please confirm the total number of consults you have completed with this patient in relation to this condition.	

Section 3. Patient history (continued)

6. Is this your patient's first episode of this condition? ☐ Yes ☐ No

If No, please provide copies of relevant reports or records.

7. Please detail the patient's current condition including cause, symptoms, your current diagnosis and the objective evidence relied on to reach this opinion. Please include copies of any evidence available and copies of any imaging performed.

8. Please provide details of other medical and allied health practitioners the patient has consulted for this condition.
Alternatively you can provide copies of any referral letters or reports from other medical and allied health professionals in lieu of completing the below.

Name and specialisation	Address and phone number	Date range of consults	
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /

9. Please detail the current treatment plan including SMART (Specific, Measurable, Achievable, Realistic, Timely) goals and progress achieved so far.

Treatment	Goals	Progress achieved so far

10. Please provide a summary of all previous treatment provided including outcomes achieved.

11. Is any additional treatment planned in the future (e.g. surgery)? ☐ Yes ☐ No

If Yes, please provide further detail including what might trigger referral for additional treatment, expected outcome and timeframes.

Section 3. Patient history (continued)

12. If your patient is not currently consulting any allied health practitioners, do you believe this would be beneficial to help with functional recovery and management of symptoms? ☐ Yes ☐ No

If Yes, provide recommended speciality below.
If No, provide further detail below.

13. Have there been any barriers to participation in the recommended treatment plan? ☐ Yes ☐ No

If Yes, please indicate what these barriers are below.

☐ Financial ☐ Logistical e.g. transport ☐ Availability e.g. waiting lists

☐ Other (specify details)

14. Are you aware of any social or psychological factors that could impact your patient's recovery and overall wellbeing? ☐ Yes ☐ No

If Yes, please provide further details.

Section 4. Medical certification

15. Please summarise your understanding of your patient's occupation including core duties.
e.g. Office Manager:
- *Sedentary physical demand level.*
- *Sits at an office desk or in meeting with staff frequently.*
- *Stands and walks about the office frequently.*
- *Repetitive movements of the hands and fingers when operating a keyboard and mouse, phones and writing instruments.*
- *Mental skills necessary include a high level of cognitive functioning with communication, listening, administrative, organisational, financial and budgeting, problem-solving, planning and decision-making capabilities.*

Section 4. Medical certification (continued)

16. If your patient is currently unable to work, or able to work on a restricted basis, please complete the following table with regards to your patient's functional tolerances.

a) Sitting	☐ Over 2 hours	☐ Up to 2 hours	☐ Up to 60 minutes	☐ Up to 30 minutes	☐ Up to 10 minutes	☐ Unable/ limited
Additional comments						
b) Standing	☐ Over 2 hours	☐ 2 hours	☐ 60 minutes	☐ 30 minutes	☐ 10 minutes	☐ Unable/ limited
Additional comments						
c) Walking	☐ Over 2 hours	☐ 2 hours	☐ 60 minutes	☐ 30 minutes	☐ 10 minutes	☐ Unable/ limited
Additional comments						
d) Lifting (consider relevance to injury e.g. position, one or two hands)	☐ Over 20kg	☐ Up to 20kg	☐ Up to 15kg	☐ Up to 10kg	☐ Up to 5kg	☐ Minimal (1 - 2kg)
Additional comments						
e) Driving	☐ Over 2 hours	☐ 2 hours	☐ 60 minutes	☐ 30 minutes	☐ 10 minutes	☐ Unable
Additional comments						
f) Travelling by other means e.g. public transport						
g) Pushing/pulling						
h) Bending/twisting/ squatting						
i) Reaching						
j) Fine motor e.g. computer use, gripping						
k) Other (please specify)						

Section 4. Medical certification (continued)

Psychological function

Functional ability	Impacted?	If Yes, please describe the impact
a) Concentration	☐ Yes ☐ No	
b) Memory	☐ Yes ☐ No	
c) Energy levels	☐ Yes ☐ No	
d) Sleep	☐ Yes ☐ No	
e) Social interaction	☐ Yes ☐ No	
f) Motivation	☐ Yes ☐ No	
g) Mood	☐ Yes ☐ No	
h) Self-care	☐ Yes ☐ No	
i) Emotional regulation	☐ Yes ☐ No	
j) Other (please specify)	☐ Yes ☐ No	

17. Could work capacity be enhanced by modifications and/or equipment (e.g. working from home, sit to stand desk, providing transport to and from office)? ☐ Yes ☐ No

If Yes, please provide further detail below.

18. What do you see as being the key factors limiting recovery and return to work (e.g. difficulty managing symptoms, uncontrolled flare-ups)?

Section 5. Certification - Inability to work

19. What period was the patient totally unable to perform any of the duties of his/her occupation (*dd/mm/yyyy*)?

Period from / / to / /

20. When do you consider that the patient may return to work on a partial/restricted or pre-disability basis (*dd/mm/yyyy*)? / /

21. Basis of return to work ☐ Restricted duties ☐ Pre-disability duties ☐ Restricted hours ☐ Pre-disability hours

Hours of work per day?

Days of work per week?

22. Please detail any restricted duties not captured in Section 4. Medical certification.

Section 5. Certification - Inability to work (continued)

23. Do you believe your patient may be fit to return to work in an alternate occupation or employment within their current education, training or experience? ☐ Yes ☐ No

If No, provide details in relation to why they may not be fit to return.
If Yes, provide details in relation to alternate employment options you believe may be suitable.

Section 6. Other information

24. Are you completing claim forms on behalf of the patient for any other company in respect of this condition? ☐ Yes ☐ No

If Yes, please provide details.

25. In your medical opinion, what is your patient's estimated life expectancy inclusive of all reasonable treatment options?
Skip if not applicable to your patient's condition.

☐ < 12 months ☐ 24 to 36 months ☐ N/A

☐ 12 to 24 months ☐ > 36 months

Additional comments

Please use this space if required.

Please attach copies of any medical reports, medical certificates or test results you may have in your possession and return the completed form to
Claims Department, MetLife Insurance Limited, GPO Box 3319, Sydney NSW 2001
or email auservices@metlife.com

For assistance with the completion of this form, please call us on 1300 555 625
Monday to Friday 8am - 6pm AEST.

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