pnb MetLife
Milkar life aage badhaein

Doctor's Certificate (For Critical Illness Claims)

Personal Details

Name of the patient: _____

Father / Spouse's Name _____

Age:_____ Gender: ☐ Male ☐ Female

Address: _____

_____

City _____ State _____ Country _____PIN Code:_____

Hospital Details

Outpatient/In-patient No: _____(If In Patient) From _____to_____

Hospital Name: _____

Name of Critical Illness *(As per the product)*

☐ Heart Attack	☐ Cancer	☐ Coma	☐ Angioplasty	☐ Cardiomyopathy	☐ Paralysis	☐ Deafness
☐ Surgery to Aorta	☐ Multiple Sclerosis	☐ Loss of Speech	☐ Alzheimer's Disease	☐ Loss of Limbs		
☐ CABG (Coronary Artery Bypass Surgery)	☐ Apallic Syndrome	☐ Benign Brain Tumor	☐ End Stage Liver Disease			
☐ Major Head Trauma	☐ Aplastic Anaemia	☐ Parkinson's Disease	☐ Primary Pulmonary Hypertension			
☐ Motor Neuron Disease	☐ Kidney Failure	☐ Major Burns	☐ Chronic Lung Disease	☐ Stroke	☐ Blindness	
☐ Brain Surgery	☐ Major Organ Transplant	☐ Heart Valve Surgery	☐ SLE with Lupus Nephritis	☐ Poliomyelitis		
☐ Muscular Dystrophy	☐ Medullary Cystic Disease	☐ Loss of Independent Existence	☐ Terminal Illness			

Nature of Habits

☐ Smoking ☐ Alcohol ☐ Tobacco ☐ Drugs if yes, duration of consumption_____

Quantity consumed _____ Others (Please Specify)_____

Diagnosis & Treatment

Date of First Consultation/diagnosis: _____

What were the symptoms / illness / disease? _____

Which investigations / tests were performed: _____

Duration of symptoms / Illness / Disease: _____

Diagnosis made and Informed to the patient: _____

Interval between onset and diagnosis: _____ Years _____ Months _____Days

Antecedent conditions related or contributing but not related to the Illness: _____

_____

Are you aware if patient consulted any other doctor / hospital apart from you? (If yes, details thereof) ☐ Yes ☐ No_____

_____

Was the patient referred to you by any other doctor? If "Yes", please provide the details: ☐ Yes ☐ No _____

_____

Medical History

Have you ever treated the deceased during last 5 years, prior to final illness? ☐ Yes ☐ No If Yes;

Details of consultation in last 5 years	1	2	3	4	5
Date of consultation					
Patient presented with complaints of					
Name of Investigations/tests prescribed					
Dates on which the tests were done and the results					
Name and address of the laboratory where the tests were done					
Treatment / Medication given					

Declaration

The above statements are true and complete to the best of my knowledge and belief and as per the records maintained by me/hospital/clinic:

Name of the Doctor		**Signature of the Doctor**	**Doctor/Hospital seal**
Qualification of the Doctor			
Regd. no. of the Doctor			
Contact no. of the Doctor			
Email id of the Doctor			
Date			