

Mental Health Conditions Questionnaire - Physician

(To be filled by the Physician)

Application Number Branch 1. Please state the diagnosis of the disorder:	Name of the Life Insured						
2 When did the symptoms first occur? 3. What were the presenting symptoms? 4. How many times has the patient visited you in the last 12 months? 5. Please describe any precipitating factors that may have caused or exacerbated the patient's symptoms: 6. Has there been more than one episode? 7. Please advise the date and duration of each episode: 8. Has the patient now fully recovered? 1. If 'Yes', please advise since when: ii. If 'Yes', please advise since when: iii. If 'Wo', please provide full details of any residual symptoms: iii. Are the patient's work, social and domestic situations now stable? Yes No N' H'No', please provide details: 9. Have there been any suicidal thoughts, tendencies or actual suicide attempts? If 'Yes', please give full details, including the dates: 10. Please advise on time taken off-work due to the mental health condition(s) (i.e. duration, reason): ii. Are there been any suicidal thoughts, tendencies or actual suicide attempts? If 'Yes', please give full details, including name and dosage: iii. Arey for Lithium treatment. i. Current medication, including name and dosage: iii. Ary specialis/psychiatization), including rames	Application Number		Branch				
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shall form part of the contract between my patient and the company. Place: Date: Date: Signature of the Life Insured Name of the Physician:	 11. Please give details of the treatment: i. Current medication, including name and dosage:						
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Signature of the Physician:							
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Please print your name and add clinic's stamp.							

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