

DOCTOR'S CERTIFICATE FOR PARALYSIS/ STROKE

POLICY NUMBER

Date: DD/MM/YYYY

Personal details of the Patient (Life Assured):

- Full Name of Patient: _____
- Date of Birth: DD/MM/YYYY

Clinical Manifestation:

- Date of first Diagnosis: DD/MM/YYYY
- Duration since it is Diagnosed: _____ Years _____ Months _____ Days
- Progress of Patient: _____
- Stimulating Factors: _____
- Any history of same illness: - ☐ *YES ☐ NO *If yes please provide the treatment records

Medical History:

Tick if Yes	Factors	Comments
☐	Hypertension	
☐	Diabetes	
☐	Dyslipidaemia	
☐	TIA/Stroke	
☐	Heart Disease	
☐	Valvular/AF/Ischaemic	
☐	Peripheral vascular disease	
☐	Carotid Bruit (due to Carotid Artery Stenosis or Atheroma)	
☐	Smoking	
☐	Deep Vein Thrombosis	
☐	Any other condition	

Medical Investigation & Findings:

- Blood: _____
- ECG: _____
- 2-D Echo: _____
- Imaging: _____
- CT Brain: _____
- MRI Brain: _____
- Any Other: Please specify in detail: _____

Deficit Conditions:

Sr.	Symptom	Sensory	Motor	Reversible (Yes/No)
1.	Hemiparesis - left side			
2.	Hemiparesis – right side			
3.	Hemiplegia – left side			
4.	Hemiplegia – right side			
5.	Loss of Speech / Slurred Speech			

Are these deficits a form of – (Please select as appropriate)

- ☐ Transient ischemic attacks (TIA)
- ☐ Traumatic injury of the brain
- ☐ Vascular disease affecting only the eye or optic nerve or vestibular functions.

Course of Treatment:

- Is there any current neurological deficit ☐ *Yes ☐ No: *If yes please mention the same in detail
- Is there any improvement in the neurological deficit from the date of diagnosis? ☐ *Yes ☐ No
*If yes, how would you rate the improvement, if asked in percentages - _____ %
- Can the patient perform below mentioned activities of daily living comfortably?

Tick if Yes	Activities	Comments
	Mobility	
		The ability to move indoors from room to room on level surfaces
	Transferring	
		The ability to move from a bed to an upright chair or wheelchair and vice versa
	Dressing	
		The ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances
	Washing	
		The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means
	Feeding	
		The ability to feed oneself once food has been prepared and made available
	Toileting	
		The ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene

Prognostication:

- Is paralysis permanent? ☐ Yes ☐ No
- Is there any hope of recovery? ☐ Yes ☐ No

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			



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