CTP INSURANCE REGULATOR

CTP Insurance Claims Medical Certificate

This form is to be completed by the assessing Medical Practitioner.

Patient's full name	Patient's date of birth

Date of accident	Insurer	Claim number

Date of initial consultation	How long has the patient attended your practice?

Provisional medical diagnosis and Description of injury or symptoms.

Clinical Findings (symptoms, results of any investigations and details of treatment to date)

Patient admitted to Hospital?	Name of Hospital	Duration of stay
◯ Yes ◯ No		

Treatment likely to be required:

◯ Nil	◯ Short Term (<6 weeks)	◯ Medium Term (6–12 weeks)	◯ Long Term (>12 weeks)

Recommended treatment and Advice to patient aimed at assisting injury recovery

Referred to:	Type	Name of provider
☐ Radiologist / Imaging		
☐ Specialist		
☐ Therapy		
☐ Other (including prescriptions)		

Describe patient's activity and participation abilities, and limitations / restrictions	Describe patient's fitness for employment
◯ Normal :	Fit to resume normal duties on:
◯ Impaired :	Fit to resume alternative duties on:
◯ Significantly Impaired :	Unfit for normal duties from: to

Medical Practitioner's Information

Name (please print)	Provider number

Practice / Hospital name and address

Telephone number	Professional qualification

I declare that I am a Registered Medical Practitioner and to the best of my knowledge the information provided here is true and correct

Signed: Dated: