The Insular Life Assurance Company, Ltd.
Insular Life Corporate Centre, Insular Life Drive
Filinvest Corporate City, Alabang, 1781 Muntinlupa City
E-mail: headofc@insular.com.ph I Website: www.insularlife.com.ph
Tel.: (632) 8-582-1818 I VAT REG. TIN 000-464-124-000

Neurological Evaluation Form

Patient's Complete Name: _____

Please provide detailed answers to the following questions:

1. What is the diagnosis of the patient? Is this inherited, congenital or acquired?

_____

2. Can you list down all physical and mental/neurologic disabilities of the patient as a result of his illness/accident?

_____

_____

_____

3. What are the daily living activities that the patient can perform? Can the patient...

YES	NO	
☐	☐	a) wash, bathe, and/or shower (including getting into and out of the bath or shower) such that an adequate level of personal hygiene can be maintained?
☐	☐	b) put on and take off, secure and unfasten all necessary garments and any braces, artificial limb or other surgical appliances?
☐	☐	c) move from a bed to an upright chair or wheelchair and vice versa or get on and off a toilet or commode?
☐	☐	d) move from one room to another on a level surface, in the patient's normal place of residence?
☐	☐	e) manage bowel and bladder functions such that an adequate level of personal hygiene can be maintained?
☐	☐	f.) feed himself once food and drink have been prepared and made available?

4. Does patient have language deficits, spoken or written?

_____

_____

5. Does patient have communication problem in expressing and understanding?

_____

_____

6. Does patient suffer from headaches, seizure, easy fatigability, sleep disorder?

_____

_____

7. Does patient show inappropriate behavior, impaired social skills, unstable emotion?

_____

_____

8. Does patient have problems with cognition?

- Thinking _____
- Reasoning _____
- Information processing _____
- Memory Loss _____
- Problem Sol ving _____

9. What are the results of the most recent diagnostic examinations done on the patient? (e.g. CT scan,MRI, Blood test, ECG, and Chest XRay) Please indicate inclusive dates.

_____

_____

_____

I hereby certify that the answers given above are full, complete and true.

_____ _____

Physician's Full Name and & Signature Date

License / PTR No.: _____
Valid until : _____

Hospital/Clinic Address: _____