# Physicianâ€™s Statement for Stroke Insurance Evaluation

## Patient Information

Full Name

Date of Birth

Patient ID/Policy No.

## Clinical Details

Date of Stroke Diagnosis

Date of Onset of Symptoms

Type of Stroke

e.g., Ischemic, Hemorrhagic

Imaging (CT/MRI) Performed

Yes / No

Describe Clinical Findings

Neurological Deficits (if any)

## Relevant Medical History

Medical / Surgical / Family History

## Physicianâ€™s Certification

I hereby certify that the above statements are true and accurate to the best of my knowledge.

Physicianâ€™s Signature

Date

Physicianâ€™s Name & Registration No.