

Stroke & Cerebrovascular Questionnaire

Claims Administrator:
Consociate • Dansig
Attn: Underwriting
111 E. Decatur Street, P.O. Box 1068
Decatur, IL 62525
Phone: (888) 242-4357
Fax: (217) 451-9088

Group name: _____

Employee name: _____

Dependent name (if condition is for dependent) _____

Age: _____ Height: _____ Weight: _____

1. What condition has been diagnosed? TIA (mini stroke) stroke, aneurysm (state location), other? _____

What type? (subdural, epidural, cerebral, subarachnoid, intracerebral, other) _____

Was it caused by bleed, blood clot, other? _____

2. Age at diagnosis _____ Recurrences? When? _____

3. What treatment was received and when? Include any surgery, hospitalizations, and medications: _____

Medication name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Have any tests been done? Yes or No If yes, give test name, date and results: _____

5. What problems or symptoms (complications) have been experienced with this condition? _____

6. How often does the person visit the Doctor's office or medical clinic for this condition _____ When was the last time seen and what was the result? _____

7. Have future tests, surgery or treatment been scheduled, prescribed or recommended? _____ If yes, please explain _____

8. Is this person able to care for themselves with activities of daily living, i.e. dressing, bathing/showering, feeding self? If no, explain _____

Please be advised that you may be required to submit medical records.

Employee signature: _____ Date: _____

