SPECIAL BLOOD SUGAR TOLERANCE REPORT

Proposal No. / Policy No. _________________________

Full Name of Life to be Assured: ____________________________ Age _________ Years Sex_________

INSTRUCTIONS FOR THE PATHOLOGIST

1. The observations should be made in the morning in the fasting state and 2 hours after meals.
2. The pathologist should indicate the method of Blood sugar estimation employed and the normal values.
3. Each column should be filled completely in every case.
4. Please insist on the proposer signing in your presence. A form on which the proposer has already put his signature should not be used.

<table>
<thead>
<tr>
<th>SAMPLE</th>
<th>Time O’clock</th>
<th>Blood Sugar %</th>
<th>Urine Glucose %</th>
<th>Acetone Bodies</th>
<th>Normal Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fasting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Hrs after meals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

INTERPRETATION: __________________________________________

Please state the method of Blood Sugar Estimation employed ______________________________________

Queries to be answered by the Life to be Assured

1. Time of taking food on the day of the test:
   __________________________________________
2. Details of food taken on the day of the test:
   __________________________________________
3. Any Medication – Name of the drug & its dosage
   __________________________________________

Dated at __________________ on the _______ day of _______ 20____ at ______ am / pm

Signature of the Life to be Assured

______________________________

Signature of the Introducer:
(Agent / Development Officer)
Name: ________________________
Code No. ______________________

I Certify that the proposer / LA has put his /her Signature alongside in my presence

______________________________

Signature of the Pathologist
Name: ________________________
Address: ______________________
Qualification: ______________________
Code No. ______________________