



ATTENDING PHYSICIAN'S STATEMENT

Critical Illness – Medullary Cystic Disease

To be completed by Registered Medical Practitioner at Assured's / Claimant's own expense

Policy No.	NRIC No.	Age																											
Name of Assured		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female																											
I) General Information																													
<p>1. (a) Are you the Assured's usual medical physician? (b) If "Yes", over what period do your records extend?</p>	<p>1. (a) <input type="checkbox"/> Yes <input type="checkbox"/> No (b) _____ _____</p>																												
<p>2. (a) When were you first consulted for this illness? (b) What were the symptoms/complaints? (c) How long had the symptoms/complaints existed :- (i) According to the patient? (ii) In your medical opinion?</p>	<p>2. (a) _____ (DD/MM/YYYY) (b) _____ (c) (i) _____ Day/s _____ Week/s _____ Month/s _____ Year/s (ii) _____ Day/s _____ Week/s _____ Month/s _____ Year/s</p>																												
<p>3. (a) Has the Assured previously suffered from this illness or any related illnesses? (b) If "Yes", please give dates of consultations and the resulting diagnosis. (c) Was the patient referred to you? (i) If Yes, when? (ii) Reasons for referral? (iii) Name and address of the referral doctors.</p>	<p>3. (a) <input type="checkbox"/> Yes <input type="checkbox"/> No (b) _____ _____ (c) <input type="checkbox"/> Yes <input type="checkbox"/> No (i) _____ (DD/MM/YYYY) (ii) _____ (iii) _____</p>																												
<p>4. (a) On what date was the diagnosis made? (b) On what date was the Assured first made aware of it?</p>	<p>4. (a) _____ (DD/MM/YYYY) (b) _____ (DD/MM/YYYY)</p>																												
<p>5. Please state if there is anything in the Assured's family history which would have increased the risk of this illness.</p>	<p>5. _____ _____</p>																												
<p>6. Which of the following factors are present? Date of Onset (DD/MM/YYYY)</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:40%;">a) Past history of controlled hypertension</td> <td style="width:10%;">Yes / No</td> <td style="width:50%;">_____</td> </tr> <tr> <td>b) Past history of uncontrolled hypertension</td> <td>Yes / No</td> <td>_____</td> </tr> <tr> <td>c) Diabetes Mellitus</td> <td>Yes / No</td> <td>_____</td> </tr> <tr> <td>d) Obesity</td> <td>Yes / No</td> <td>_____</td> </tr> <tr> <td>e) Chronic smoker</td> <td>Yes / No</td> <td>_____</td> </tr> <tr> <td>f) Heavy drinker</td> <td>Yes / No</td> <td>_____</td> </tr> <tr> <td>g) Stress</td> <td>Yes / No</td> <td>_____</td> </tr> <tr> <td>h) Hyperlipidaemia</td> <td>Yes / No</td> <td>_____</td> </tr> <tr> <td colspan="3">i) Others, please specify : _____ _____</td> </tr> </table>			a) Past history of controlled hypertension	Yes / No	_____	b) Past history of uncontrolled hypertension	Yes / No	_____	c) Diabetes Mellitus	Yes / No	_____	d) Obesity	Yes / No	_____	e) Chronic smoker	Yes / No	_____	f) Heavy drinker	Yes / No	_____	g) Stress	Yes / No	_____	h) Hyperlipidaemia	Yes / No	_____	i) Others, please specify : _____ _____		
a) Past history of controlled hypertension	Yes / No	_____																											
b) Past history of uncontrolled hypertension	Yes / No	_____																											
c) Diabetes Mellitus	Yes / No	_____																											
d) Obesity	Yes / No	_____																											
e) Chronic smoker	Yes / No	_____																											
f) Heavy drinker	Yes / No	_____																											
g) Stress	Yes / No	_____																											
h) Hyperlipidaemia	Yes / No	_____																											
i) Others, please specify : _____ _____																													

II) Details of the Assured's Illness

<p>1. Please provide full and exact details of the diagnosis.</p>	<p>1. _____ _____ _____</p>
---	---

<p>2. Please confirm the diagnosis of the medullary cystic disease</p> <p>(a) Please give full details of any polyuria, polydipsia, growth retardation and renal failure.</p> <p>(b) Please give full details of diagnostic tests performed and results e.g. renal biopsy / MRI / CT scan / Ultrasound / renal function test</p>	<p>2.</p> <p>(a) _____ _____</p> <p>(b) _____ _____</p>
--	---

<p>3. Please provide names, dates and addresses of doctors or hospitals which the Assured had been referred and / or admitted to.</p>	<p>3. _____ _____ _____</p>
---	---

<p>4. Has the Assured suffered from / been treated for any other illnesses or complaints other than this Critical Illness? If "Yes", please provide full details.</p>	<p>4. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
---	--

<p>5. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.</p>	<p>5. _____ _____ _____ _____</p>
--	--

Note: Please enclose copies of all reports including renal biopsy, ultrasound, blood test, renal function test and relevant hospital reports that are available.

I hereby certify that I have personally examined and treated the Assured for his / her injuries / illnesses described above and that the facts as stated above represent my medical opinion of his / her condition.

 Signature of Attending Physician

 Name & Address
 (Official Stamp)

 Contact No.

 Qualification

 Date
 (DD/MM/YYYY)