ATTENDING PHYSICIAN'S STATEMENT
Critical Illness - Stroke
To be completed by Registered Medical Practitioner at Assured's / Claimant's own expense

Policy No.	NRIC No.	Age
Name of Assured	Sex ☐ Male ☐ Female	

I) General Information

1. (a) Are you the Assured's usual medical physician?	1. (a) ☐ Yes ☐ No
(b) If "Yes", over what period do your records extend?	(b) _____
2. (a) When were you first consulted for this illness?	2. (a) _____ (DD/MM/YYYY)
(b) What were the symptoms/complaints?	(b) _____
(c) How long had the symptoms/complaints existed :-	
(i) According to the patient?	(c) (i) _____ Day/s _____ Week/s _____ Month/s _____ Year/s
(ii) In your medical opinion?	(ii) _____ Day/s _____ Week/s _____ Month/s _____ Year/s
3. (a) Has the Assured previously suffered from this illness or any related illnesses?	3. (a) ☐ Yes ☐ No
(b) If "Yes", please give dates of consultations and the resulting diagnosis.	(b) _____
(c) Was the patient referred to you?	(c) ☐ Yes ☐ No
(i) If Yes, when?	(i) _____ (DD/MM/YYYY)
(ii) Reasons for referral?	(ii) _____
(iii) Name and address of the referral doctors.	(iii) _____
4. (a) On what date was the diagnosis made?	4. (a) _____ (DD/MM/YYYY)
(b) On what date was the Assured first made aware of it?	(b) _____ (DD/MM/YYYY)
5. Please state if there is anything in the Assured's family history which would have increased the risk of this illness.	5. _____

6. Which of the following factors are present?

		Date of Onset (DD/MM/YYYY)
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

1. Please provide full and exact details of the diagnosis.	1. _____
2. Please describe the initial episode. (a) Date of the Episode. (b) Nature of the Episode. (c) Duration of the Acute Symptoms. (d) Date of Return to Normal Activities and / or the Assured's Physical and Mental capabilities. (e) Date of last consultation.	2. (a) _____ (DD/MM/YYYY) (b) _____ (c) _____ (d) _____ (DD/MM/YYYY) (e) _____ (DD/MM/YYYY)
3. Did the Assured suffer from a neurological sequalae which lasted more than 24 hours or lasted more than 3 months or lasted more than 6 months? Please tick the relevant. (b) Please comment on any neurological sequela which had lasted as per the above time frame. (c) Are these sequela permanent?	3. (a) ☐ Lasted more than 24 hours or ☐ Lasted more than 3 months or ☐ Lasted more than 6 months (b) _____ (c) ☐ Yes ☐ No
4. Has there been an infarction of brain tissue cerebral haemorrhage or embolization from an extracranial source?	4. ☐ Yes ☐ No
5. Was the Assured treated by any other doctors or hospitals? If "Yes", please provide us the dates, names and addresses of the doctors / hospitals.	5. ☐ Yes ☐ No _____
6. Has the Assured suffered from / been treated for any other illnesses or complaints other than this Critical Illness? If "Yes", please provide full details.	6. ☐ Yes ☐ No _____
7. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.	7. _____

Note: Please enclose copies of all reports, radiological procedures, CT scans, laboratory tests, other imaging procedures, etc. and any relevant 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.

_____ Qualification _____

Signature of Attending Physician

Name & Address _____ Date _____

(Official Stamp)

(DD/MM/YYYY)

Contact No. _____