ATTENDING PHYSICIAN'S STATEMENT

Female Product – Reconstructive Surgery of Breast Cancer Benefit / Breast Lumpectomy / Mastectomy

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? (b) If "Yes", over what period do your records extend?	1. (a) ☐ Yes ☐ No (b) _____ _____
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?	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
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.	3. (a) ☐ Yes ☐ No (b) _____ _____ (c) ☐ Yes ☐ No (i) _____ (DD/MM/YYYY) (ii) _____ (iii) _____
4. (a) On what date was the diagnosis made? (b) On what date was the Assured first made aware of it?	4. (a) _____ (DD/MM/YYYY) (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 : _____

_____

7. How long has the condition been medically documented?	7. _____
8. What was the site and histology of the tumor? (Please provide copy of the histology report)	8. _____ _____
9. Is the condition malignant?	9. ☐ Yes ☐ No
10. Is there focal autonomous new growth of carcinomatous cells?	10. ☐ Yes ☐ No
11. Is there invasion of normal tissues by the carcinomatous cells? If "Yes", what is the stage of the invasion?	11. (a) ☐ Yes ☐ No (b) _____
12. (a) Has a mastectomy been performed as a direct result of primary breast cancer? (b) If "No", please specify type of surgery done and date performed.	12. (a) ☐ Yes Date performed_____(DD/MM/YYYY) ☐ No (b) _____ _____
13. Has reconstructive surgery of the breast been performed? If "Yes", please give details, dates and costs.	13. ☐ Yes ☐ No _____ _____
14. Present condition of the Assured.	14. _____ _____
15. Prognosis.	15. _____ _____
16. Was the Assured treated by any other doctors or hospitals? If "Yes", please provide us the dates, names and addresses of the doctors / hospitals.	16. ☐ Yes ☐ No _____ _____
17. Has the Assured suffered from/been treated for any other illnesses or complaints other than this condition? If "Yes", please provide full details.	17. ☐ Yes ☐ No _____ _____
18. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.	18. ☐ Yes ☐ No _____ _____

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. _____