ATTENDING PHYSICIAN'S STATEMENT
Female Product– Tetralogy Fallot
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. When were you first consulted for this illness?	2. _____ (DD/MM/YYYY)
3. Please state if there is anything in the Assured's family history which would have increased the risk of this illness.	3. _____

4. Was the Assured treated by any other doctors or hospitals? If "Yes", please provide us the dates, names and addresses of the doctors or hospitals. ☐ Yes ☐ No

_____

_____

_____

5. How long has the condition been medically documented?

_____

_____

_____

6. When was the diagnosis made? Please state the date. _____(DD/MM/YYYY)

7. Please state if there is severe or total right ventricular outflow tract obstruction.

_____

_____

_____

8. Please state if there is ventricular septal defect allowing right ventricular unoxygenated blood to bypass the pulmonary artery and enter the aorta directly.

_____

_____

_____

9 Please give dates and details of any operations performed on the Assured. Please attach the relevant reports supporting this diagnosis.

_____

_____

_____

10. Present Condition of the Assured.

_____

_____

_____

_____

_____

11. Prognosis.

_____

_____

_____

_____

12. Please state if the Assured has previously suffered / been treated for any other illnesses / complaints other than this condition.

_____

_____

_____

_____

13. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.

_____

_____

_____

_____

_____

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. _____