AIA PUBLIC TAKAFUL

ATTENDING PHYSICIAN'S STATEMENT

Critical Illness - Coronary Artery Disease Requiring Surgery/Other Serious Coronary Artery Disease/ Angioplasty/Heart Attack

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

Certificate No:	IC No:	Age:
Name of Person Covered:		Gender: ☐ Male ☐ Female

Note - Please tick (✓) the relevant diagnosis

☐ **Coronary Artery Disease Requiring Surgery**
☐ **Other Serious Coronary Artery Disease**
☐ **Heart Attack**
☐ **Angioplasty and Other Invasive Treatments for Coronary Artery Disease**

Part I - General Information

1. (a) Are you the Person Covered'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) _____ (MM/DD/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 Person Covered 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) _____ (MM/DD/YYYY) (ii) _____ (iii) _____
4. (a) On what date was the diagnosis made? (b) On what date was the Person Covered first made aware of it?	4. (a) _____ (MM/DD/YYYY) (b) _____ (MM/DD/YYYY)
5. Please state if there is anything in the Person Covered's family history which would have increased the risk of this illness.	5. _____

6. Which of the following factors are present?

		Date of Onset (MM/DD/YY)
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 : _____

Part II - Details of the Person Covered's Illness

1. Please provide full and exact details of the diagnosis.	1. _____
2.. Please describe the extent of the disease. (a) Which arteries are involved and what is the degree of narrowing (%) in respect of each involved artery? (b) Was coronary arteriography performed?	2. (a) _____ (b) ☐ Yes Date Performed _____ (MM/DD/YYYY) ☐ No
3. What is the nature of treatment? (a) Was open heart surgery performed? (b) If "Yes", state the number and sites of grafts inserted. (c) Was balloon angioplasty, atherectomy or laser treatment done? If "Yes", please state which treatment was done. (d) What other forms of treatment were rendered (if any)?	3. (a) ☐ Yes Date Performed _____ (MM/DD/YYYY) ☐ No (b) _____ (c) ☐ Yes Date Performed _____ (MM/DD/YYYY) ☐ No Treatment _____ (d) _____ Date _____(MM/DD/YYYY)
4. Please describe the Heart Attack (For Heart Attack) (a) Date of Attack. (b) Was there a history of typical prolonged chest pain? (c) Was there a serial elevation of cardiac enzymes (CPK -MB) documented. (d) Were there any changes in ECG indicative of a myocardial infarction from this occurrence? (e) Troponin T > 1.0 ng/ml or equivalent threshold with other Troponin I methods? (f) Duration of the Acute Symptoms. (g) Date of Return to Normal Activities and/or the Person Covered's Present Limitations Physical and Mental	4. (a) _____ (MM/DD/YYYY) (b) ☐ Yes ☐ No (c) ☐ Yes ☐ No (d) ☐ Yes ☐ No (e) ☐ Yes ☐ No (f) _____ (g) _____ (MM/DD/YYYY)
5. Was the Person Covered 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 Person Covered suffered from / been treated for any other illnesses or complaints other than this Critical Illness? If "Yes", please provide 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. ☐ Yes ☐ No _____

Note: Please enclose copies of post bypass report, angiograms, Post Percutaneous Transluminal Coronary Angioplasty (PTCA), ECGs, Cardiac Enzymes assays, Troponin T test, Echocardiogram and all reports including X-rays, CT scans, any other imaging studies, laboratory evidence, etc. and any relevant hospital reports that are available.

I hereby certify that I have personally examined and treated the Person Covered 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

Qualification: _____

Name & Address:
(Official Stamp) _____

_____

Date: _____
(MM/DD/YYYY)

Contact No.: _____