AIA PUBLIC TAKAFUL

ATTENDING PHYSICIAN'S STATEMENT

Critical Illness & Female Product– Systemic Lupus Erythematosus (S.L.E) with Lupus Nephritis

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

Part I - General Information

1. (a) Are you the Person Covered'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) _____ (MM/DD/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 Person Covered 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) _____ (MM/DD/YYYY)
(ii) Reasons for referral?	(ii) _____
(iii) Name and address of the referral doctors.	(iii) _____
4. (a) Has S.L.E been definitely diagnosed?	4. (a) ☐ Yes ☐ No
(b) On what date was the diagnosis made?	(b) _____ (MM/DD/YYYY)
(c) On what date was the Person Covered first made aware of it?	(c) _____ (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. Other physicians or medical facilities the Person Covered has consulted for this condition.

_____

7. Which of the following factors are present?

		Date of Onset (MM/DD/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 : _____

8. Please confirm which of the following clinical manifestations is exhibited by the Person Covered.

	Yes	No		Yes	No		Yes	No
Malar rash	☐	☐	Arthritis	☐	☐	Lumphopenia [<1,500/μL]	☐	☐
Discoid rash	☐	☐	Serositis	☐	☐	Haemolytic anemia	☐	☐
Photosensitivity	☐	☐	Renal disorder	☐	☐	Thrombocytopenia [<100,000/μL]	☐	☐
Oral ulcers	☐	☐	Leukopenia [<4,000/μL]	☐	☐	Neurological disorder	☐	☐

Other (please specify) _____

9. What is the nature and extent of cardiac, central nervous stem and renal impairment?

_____

10. Results & dates of following laboratory test (please provide copy of test results).

	Results	Dates (MM/DD/YYYY)
Anti-Nuclear Antibodies		
L.E. Cells		
Anti-Sm		
Anti-DNA		
Creatinine Clearance Rate		
Post record		
Latest record		

11. Date and result of renal biopsy.

_____

12. Results of other investigations, e.g. biopsy, renal functions test, etc. (please provide copy of test results).

_____

13. Details of treatment rendered.

_____

Was there any surgery performed? If "Yes", please provide details of surgical procedures ☐ Yes ☐ No

_____

14. Present Condition of the Person Covered

_____

15. Prognosis

_____

16. Please state if the Person Covered has previously suffered / been treated for any other illnesses / complaints other than this condition.

_____

17. Please confirm if Person Covered falls within either Type III to Type IV Lupus Nephritis. If yes, please specify type and degree of impairment.

_____

18. 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 Person Covered 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) (MM/DD/YYYY)

_____

Contact No.: _____