



**AIA PUBLIC  
TAKAFUL**

**ATTENDING PHYSICIAN'S STATEMENT**

**Critical Illness – Loss of Independent Existence**

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: <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Part I - General Information</b>					
1. (a) Are you the Person Covered's usual medical physician?		1. (a) <input type="checkbox"/> Yes <input type="checkbox"/> 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 :-		(c) (i) _____ Day/s _____ Week/s _____ Month/s _____ Year/s			
(i) According to the patient?		(ii) _____ Day/s _____ Week/s _____ Month/s _____ Year/s			
(ii) In your medical opinion?					
3. (a) Has the Person Covered previously suffered from this illness or any related illnesses?		3. (a) <input type="checkbox"/> Yes <input type="checkbox"/> No			
(b) If "Yes", please give dates of consultations and the resulting diagnosis.		(b) _____ _____			
(c) Was the patient referred to you?		(c) <input type="checkbox"/> Yes <input type="checkbox"/> 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) On what date was the diagnosis made?		4. (a) _____ (MM/DD/YYYY)			
(b) On what date was the Person Covered first made aware of it?		(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/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. Please give below, the details of any other doctors or specialists the Person Covered has consulted in connection with this illness.					
<u>Names</u>		<u>Addresses</u>		<u>Dates (MM/DD/YYYY)</u>	
(a) _____		_____		_____	
(b) _____		_____		_____	

<b>Part II - Details of the Person Covered's Illness</b>										
1. Please provide full and exact details of the diagnosis.	1. _____ _____									
2. Investigations Done.	2. <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 35%; text-align: center;"><u>Dates (MM/DD/YYYY)</u></td> <td style="width: 35%; text-align: center;"><u>Procedures</u></td> <td style="width: 30%; text-align: center;"><u>Results</u></td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table>	<u>Dates (MM/DD/YYYY)</u>	<u>Procedures</u>	<u>Results</u>	_____	_____	_____	_____	_____	_____
<u>Dates (MM/DD/YYYY)</u>	<u>Procedures</u>	<u>Results</u>								
_____	_____	_____								
_____	_____	_____								
3. (a) Details of Treatment Rendered.  (b) Was there any surgery performed?  (c) If "Yes", please provide details of surgical procedures.  (d) Last Date of Consultation	3. (a) _____ _____  (b) <input type="checkbox"/> Yes <input type="checkbox"/> No  (c) _____  (d) _____(MM/DD/YYYY)									
5. If the Person Covered is not bedridden, which of the following daily activities is the Person Covered NOT able to perform as a direct result of the trauma? Please check the appropriate item.        (b) Is such inability expected to be permanent?	4. (a) <input type="checkbox"/> Getting in and out of a chair without requiring physical assistance. <input type="checkbox"/> The ability to move from room to room without requiring any physical assistance. <input type="checkbox"/> The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene <input type="checkbox"/> Putting on and taking off all necessary items of clothing without requiring assistance of another person. <input type="checkbox"/> The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means. <input type="checkbox"/> All tasks of getting food into the body once it has been prepared.  (b) <input type="checkbox"/> Yes <input type="checkbox"/> No									
5. Prognosis	5. _____									
6. Has the Person Covered suffered from / been treated for any other illnesses or complaints other than this Critical Illness? If "Yes", please provide full details.	6. <input type="checkbox"/> Yes <input type="checkbox"/> No  _____  _____									
7. 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.	7. <input type="checkbox"/> Yes <input type="checkbox"/> No  _____  _____									
8. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.	8. _____  _____									
<p><b>Note:</b> Please enclose copies of all reports including biopsy, cytology reports, X-rays, CT scans, other imaging studies, laboratory evidence, surgical report, etc. and any relevant hospital reports that are available.</p>										
<p>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.</p>										
<p>_____ Signature of Attending Physician</p> <p>Name &amp; Address: _____ (Official Stamp) _____</p> <p>Contact No.: _____</p>	<p>Qualification: _____</p> <p>Date: _____ <span style="float: right;">(MM/DD/YYYY)</span></p>									