AIA PUBLIC TAKAFUL

ATTENDING PHYSICIAN'S STATEMENT
Female Product– Disseminated Intravascular Coagulation (D.I.C.)
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? (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. Other physicians or medical facilities the Person Covered has consulted in connection with this illness.

Names of Physicians / Facilities	Addresses	Dates of Consultations / Confinement Periods

7. How long has the condition been medically documented?

____

8. Was there entrance of uterine material with tissue factor activity into the maternal circulation?	8. ______
9. Has this resulted in major haemorrhage?	9. ______
10. Was the D.I.C. resulted from Abortion?	10. ☐ Yes ☐ No
11. How many weeks of pregnancy currently?	11. ______
12. Does this require treatment with frozen plasma and platelet concentrates? Please give details of treatment.	12. ______
13. Present Condition of the Person Covered.	13. ______
14. Prognosis.	14. ______
15. Please state if the Person Covered suffered from / been treated for any other illnesses or complaints other than this condition.	15. ______
16. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.	16. ______

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.: ______