


ATTENDING PHYSICIAN'S STATEMENT
Female Product– Down's Syndrome

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	
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) <input type="checkbox"/> Yes <input type="checkbox"/> No (b) _____ _____			
2. When were you first consulted for this conditions?		2. _____ (MM/DD/YYYY)			
3. Is there an extra chromosome 21?		3. <input type="checkbox"/> Yes <input type="checkbox"/> No			
4. Does the Person Covered exhibit (a) muscular hypotonicity? (b) microcephaly? (c) brachycephaly? (d) flattened occiput?		4. (a) <input type="checkbox"/> Yes <input type="checkbox"/> No (b) <input type="checkbox"/> Yes <input type="checkbox"/> No (c) <input type="checkbox"/> Yes <input type="checkbox"/> No (d) <input type="checkbox"/> Yes <input type="checkbox"/> No			
5. What is the nature and extent of retardation of physical and mental development?		5. _____ _____ _____			
6. Please state if there is anything in the Person Covered's family history which would have increased the risk of this illness.		6. _____ _____ _____			
7. How long has the condition been medically documented?		7. _____ _____			
8. Was the Person Covered treated by any other doctors or hospital? If "Yes", please provide us the dates. <input type="checkbox"/> Yes <input type="checkbox"/> No					
<u>Names of Physicians / Facilities</u>		<u>Addresses</u>		<u>Dates of Consultations / Confinement Periods</u>	

9. Please give details of clinical manifestations.					

10. Diagnostics tools, including dates & results (please provide copy of reports).

11. Present Condition of the Person Covered.

12. Prognosis.

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

14. 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.

Signature of Attending Physician

Qualification: _____

Name & Address: _____
(Official Stamp)

Date: _____

(MM/DD/YYYY)

Contact No.: _____