AIA Bhd. (790895-D)

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ATTENDING PHYSICIAN'S STATEMENT
Critical Illness – Brain Surgery
To be completed by Registered Medical Practitioner at Assured's / Claimant's own expense

Policy No.	NRIC No.	Age
Name of Assured		Sex ☐ Male ☐ Female

I) General Information

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

6. Which of the following factors are present?

Factor		Date of Onset (DD/MM/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 : ____________________

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II) Details of the Assured's Illness

1. Please provide full and exact details of the diagnosis.	1. ______________________
2. (a) Did the Assured undergo surgery of the brain ? If "Yes", please give details	2. (a) ☐ Yes ☐ No ______________________
(b) What was the reason for the surgery	(b) ______________________
(c) Brain surgery as a result of an accident?	(c) ☐ Yes ☐ No
(d) Which of the following operations procedure done?	(d)
(i) Burr hole	(i) ☐ Yes ☐ No
(ii) Transphenoidal	(ii) ☐ Yes ☐ No
(iii) Others minimal invasive	(iii) ☐ Yes ☐ No
(iv) Others, please give details	(iv) ______________________
3. Has the Assured suffered from / been treated for any other illnesses or complaints other than this Critical Illness? If "Yes", please provide full details.	3. ☐ Yes ☐ No ______________________
4. Was the Assured treated by any other doctors or hospitals? If "Yes", please provide us the dates, names and addresses of the doctors / hospitals.	4. ☐ Yes ☐ No ______________________
5. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.	5. ______________________

Note: Please enclose copies of all reports including CT scan, MRI brain scan, all the tests done and relevant hospital reports that are available

I hereby certify that I have personally examined and treated the Assured for his / her injuries / illnesses described above and that the facts as stated above represent my medical opinion of his / her condition.

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Signature of Attending Physician

Qualification ______________________

Name & Address ______________________
(Official Stamp)

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Date ______________________
(DD/MM/YYYY)

Contact No. ______________________