ATTENDING PHYSICIAN'S STATEMENT
Critical Illness – Encephalitis or Bacterial Meningitis
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

1. (a) Are you the Assured'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) _____ (DD/MM/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 Assured 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) _____ (DD/MM/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) _____ (DD/MM/YYYY)
(b) On what date was the Assured first made aware of it?	(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?

		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 : _____

_____

II) Details of the Assured's Illness

1. Please provide full and exact details of the diagnosis.	1. _____ _____
2. Please describe the extent of the illness (where applicable). (i) Encephalitis or Bacterial meningitis (a) Date of the Diagnosis (b) When was the Assured informed of the diagnosis? (c) Please state the date of the Assured's return to normal activities and/or the Assured's present physical and mental limitation. (d) Was there any significant and serious permanent neurological deficit? (e) Is the permanent neurological deficit (i) documented for more than 30 days? (ii) resulting in any inability to perform at least three (3) of the Activities of Daily living? (f) Which of the following daily activities is the Assured NOT able to perform? Please check the appropriate item. (g) Is such inability expected to be permanent? (h) Is the Assured HIV positive? (i) For bacterial meningitis, is there a presence of bacterial infection in the cerebrospinal fluid by lumbar puncture?	2. (i) (a) _____ (DD/MM/YYYY) (d) _____ (DD/MM/YYYY) (c) _____ (DD/MM/YYYY) (d) ☐ Yes ☐ No (e) (i) ☐ Yes ☐ No (ii) ☐ Yes ☐ No (f) ☐ Getting in and out of a chair without requiring physical assistance. ☐ The ability to move from room to room without requiring any physical assistance. ☐ The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene. ☐ Putting on and taking off all necessary items of clothing without requiring assistance of another person. ☐ 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. ☐ All tasks of getting food into the body once it has been prepared. (g) ☐ Yes ☐ No (h) ☐ Yes ☐ No (i) ☐ Yes ☐ No
3. Was the Assured treated by any other doctors or hospitals? If "Yes", please provide us the dates, names and addresses of the doctors / hospitals.	3. ☐ Yes ☐ No _____ _____
4. Has the Assured suffered from / been treated for any other illnesses or complaints other than this Critical Illness? If "Yes", please provide full details.	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. ☐ Yes ☐ No _____ _____

Note: Please enclose copies of all reports including X-rays, CT scan, blood test, other laboratory tests, cytology, surgical report and any 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.

_____ Qualification _____

Signature of Attending Physician

Name & Address _____ Date _____

(Official Stamp) (DD/MM/YYYY)

_____

Contact No. _____