



ATTENDING PHYSICIAN'S STATEMENT

Critical Illness – Muscular Dystrophy or Motor Neuron Disease

To be completed by Registered Medical Practitioner at Assured's / Claimant's own expense

Policy No.	NRIC No.	Age																														
Name of Assured		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female																														
Note – Please tick the relevant diagnosis <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Motor Neuron Disease																																
I) General Information																																
1. (a) Are you the Assured'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. (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) <input type="checkbox"/> Yes <input type="checkbox"/> No (b) _____ _____ (c) <input type="checkbox"/> Yes <input type="checkbox"/> 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? a) Past history of controlled hypertension b) Past history of uncontrolled hypertension c) Diabetes Mellitus d) Obesity e) Chronic smoker f) Heavy drinker g) Stress h) Hyperlipidaemia i) Others, please specify : _____	<table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:70%;"></th> <th style="width:10%; text-align: center;">Yes / No</th> <th style="width:20%; text-align: center;">Date of Onset (DD/MM/YYYY)</th> </tr> </thead> <tbody> <tr><td>a)</td><td style="text-align: center;">Yes / No</td><td>_____</td></tr> <tr><td>b)</td><td style="text-align: center;">Yes / No</td><td>_____</td></tr> <tr><td>c)</td><td style="text-align: center;">Yes / No</td><td>_____</td></tr> <tr><td>d)</td><td style="text-align: center;">Yes / No</td><td>_____</td></tr> <tr><td>e)</td><td style="text-align: center;">Yes / No</td><td>_____</td></tr> <tr><td>f)</td><td style="text-align: center;">Yes / No</td><td>_____</td></tr> <tr><td>g)</td><td style="text-align: center;">Yes / No</td><td>_____</td></tr> <tr><td>h)</td><td style="text-align: center;">Yes / No</td><td>_____</td></tr> <tr><td>i)</td><td style="text-align: center;">Yes / No</td><td>_____</td></tr> </tbody> </table>			Yes / No	Date of Onset (DD/MM/YYYY)	a)	Yes / No	_____	b)	Yes / No	_____	c)	Yes / No	_____	d)	Yes / No	_____	e)	Yes / No	_____	f)	Yes / No	_____	g)	Yes / No	_____	h)	Yes / No	_____	i)	Yes / No	_____
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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 disease. (i) Muscular Dystrophy (a) Is there any evidence of sensory disturbances, abnormal cerebrospinal fluid, or diminished tendon reflex? (b) If "Yes", please describe findings. (c) Which are the muscles involved? (ii) Motor Neurone Disease (a) When was the date of onset? (b) What is the diagnosis?	2. _____ (i) (a) <input type="checkbox"/> Yes <input type="checkbox"/> No (b) _____ _____ (c) _____ _____ (ii) (a) _____ (DD/MM/YYYY) (b) _____
3. Was the diagnosis confirmed by (i) Muscular Dystrophy (a) an electromyogram? (b) muscle biopsy? (ii) Motor Neurone Disease (a) Are there any definite evidence of appropriate and relevant neurological signs supporting the diagnosis? (b) If "Yes", please elaborate.	3. _____ (i) (a) <input type="checkbox"/> Yes <input type="checkbox"/> No (b) <input type="checkbox"/> Yes <input type="checkbox"/> No (ii) (a) <input type="checkbox"/> Yes <input type="checkbox"/> No (b) _____ _____
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. <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____ _____
5. Has the Assured suffered from / been treated for any other illnesses or complaints other than this Critical Illness? If "Yes", please provide full details.	5. <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____
6. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.	6. _____ _____ _____
Note: Please enclose copies of all post operative reports, X-rays, CT scans, and any other imaging studies, laboratory evidence, angiograms, etc. 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.	
_____ Signature of Attending Physician	Qualification _____
Name & Address _____ (Official Stamp) _____	Date _____ (DD/MM/YYYY)
Contact No. _____	