ATTENDING PHYSICIAN'S STATEMENT

Critical Illness & Female Product– Systemic Lupus Erythematosus (S.L.E) with Lupus Nephritis

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? (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) Has S.L.E been definitely diagnosed? (b) On what date was the diagnosis made? (c) On what date was the Assured first made aware of it?	4. (a) ☐ Yes ☐ No (b) _____ (DD/MM/YYYY) (c) _____ (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. Other physicians or medical facilities the Assured has consulted for this condition.

_____

7. 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 : _____

8. Please confirm which of the following clinical manifestations is exhibited by the Assured.

	Yes	No		Yes	No		Yes	No
Malar rash	☐	☐	Arthritis	☐	☐	Lumphopenia [<1,500/μL]	☐	☐
Discoid rash	☐	☐	Serositis	☐	☐	Haemolytic anemia	☐	☐
Photosensitivity	☐	☐	Renal disorder	☐	☐	Thrombocytopenia [<100,000/μL]	☐	☐
Oral ulcers	☐	☐	Leukopenia [<4,000/μL]	☐	☐	Neurological disorder	☐	☐

Other (please specify) _____

9. What is the nature and extent of cardiac, central nervous stem and renal impairment?

_____

10. Results & dates of following laboratory test (please provide copy of test results).

	Results	Dates (DD/MM/YYYY)
Anti-Nuclear Antibodies		
L.E. Cells		
Anti-Sm		
Anti-DNA		
Creatinine Clearance Rate		
Post record		
Latest record		

11. Date and result of renal biopsy.

_____

12. Results of other investigations, e.g. biopsy, renal functions test, etc. (please provide copy of test results).

_____

13. Details of treatment rendered.

_____

Was there any surgery performed? If "Yes", please provide details of surgical procedures ☐ Yes ☐ No

_____

14. Present Condition of the Assured

_____

15. Prognosis

_____

16. Please state if the Assured has previously suffered / been treated for any other illnesses / complaints other than this condition.

_____

17. Please confirm if Assured falls within either Type III to Type IV Lupus Nephritis. If yes, please specify type and degree of impairment.

_____

18. 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 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. _____