



ATTENDING PHYSICIAN'S STATEMENT

Female Product– Ectopic Pregnancy / Molar Pregnancy / Eclampsia

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												
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. What were the precipitating factors?	3. _____ _____													
4. (a) Has the Assured a previous history of ectopic pregnancy or molar pregnancy? (b) If "Yes", please give dates of consultations and the resulting diagnosis made.	4. (a) <input type="checkbox"/> Yes <input type="checkbox"/> No (b) _____ _____													
5. (a) On what date was the diagnosis made? (b) On what date was the Assured first made aware of it?	5. (a) _____ (DD/MM/YYYY) (b) _____ (DD/MM/YYYY)													
6. Please state if there is anything in the Assured's family history which would have increased the risk of this illness.	6. _____ _____													
7. Other physicians or medical facilities the Assured has consulted in connection with this illness.														
<table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black; width: 60%;">Names of Physicians / Facilities</th> <th style="text-align: left; border-bottom: 1px solid black; width: 20%;">Addresses</th> <th style="text-align: left; border-bottom: 1px solid black; width: 20%;">Dates of Consultations / Confinement Periods</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table>			Names of Physicians / Facilities	Addresses	Dates of Consultations / Confinement Periods	_____	_____	_____	_____	_____	_____	_____	_____	_____
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_____	_____	_____												
_____	_____	_____												
_____	_____	_____												
8. How long has the condition been medically documented? _____ _____ _____														

<p>9. Did implantation of a fertilized ovum occur outside the uterine cavity?</p>	<p>9. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>_____</p> <p>_____</p>
<p>10. Please provide details of how the ectopic pregnancy or molar pregnancy was confirmed.</p>	<p>10. _____</p> <p>_____</p>
<p>11. Was the pregnancy terminated by laparotomy or laparoscopic surgery? Please give details including whether the pregnancy termination was elective or if emergency surgery was required. (Please attach copies of biopsy or any relevant reports or special investigations)</p>	<p>11. _____</p> <p>_____</p> <p>_____</p>
<p>12. For Eclampsia, whether her pregnancy has the following:-</p> <p>(a) Hypertension</p> <p>(b) Convulsions/seizures</p> <p>(c) Proteinuria</p> <p>(d) Oedema</p> <p>Please attach copies of relevant reports or special investigations.</p>	<p>12.</p> <p>(a) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(b) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(c) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(d) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>_____</p>
<p>13. Present condition of the Assured.</p>	<p>13. _____</p> <p>_____</p>
<p>14. Prognosis</p>	<p>14. _____</p> <p>_____</p>
<p>15. Please state if the Assured suffered from / been treated for any other illnesses or complaints other than this condition.</p>	<p>15. _____</p> <p>_____</p> <p>_____</p>
<p>16. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.</p>	<p>16. _____</p> <p>_____</p> <p>_____</p>

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. _____