ATTENDING PHYSICIAN'S STATEMENT
Female Product– Spina Bifida
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. When were you first consulted for this illness?	2. _____ (DD/MM/YYYY)
3. Please state if there is anything in the Assured's family history which would have increased the risk of this illness.	3. _____
4. Please provide names, addresses and dates of the Assured's consultation with other physicians or medical facilities for this condition.	4. _____
5. How long has the condition been medically documented?	5. _____
6. When was the diagnosis made? Please state the date.	6. _____ (DD/MM/YYYY)

7. Please give details of all investigations conducted as part of the diagnosis (including dates and results). Please attach the relevant reports, echocardiogram, X-ray etc. supporting this diagnosis.

Date Results

_____

_____

_____

8. Were there clinical manifestations of meningomyelocele or meningocele?

_____

_____

_____

9 Please give details of resultant neurological deficits.

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_____

10. Present Condition of the Assured.

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_____

11. Prognosis.

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

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13. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.

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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. _____