AIA PUBLIC TAKAFUL

## ATTENDING PHYSICIAN'S STATEMENT

### Female Product – Carcinoma-in-situ (CIS) of Cervix or Carcinoma-in-situ (CIS) of Breast

**To be completed by Registered Medical Practitioner at Person Covered's / Claimant's own expense**

| Certificate No: | IC No: | Age: |
|---|---|---|
| Name of Person Covered: | | Gender: ☐ Male ☐ Female |

**Part I - General Information**

| | |
|---|---|
| 1. (a) Are you the Person Covered'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) _____ (MM/DD/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 Person Covered 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) _____ (MM/DD/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) _____ (MM/DD/YYYY) |
| (b) On what date was the Person Covered first made aware of it? | (b) _____ (MM/DD/YYYY) |
| 5. Please state if there is anything in the Person Covered's family history which would have increased the risk of this illness. | 5. _____ |

6. Which of the following factors are present?

| | | Date of Onset (MM/DD/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 : _____

_____

| | |
|---|---|
| 7. How long has the condition been medically documented? | 7. _____ |
| 8. If the diagnosis was CIS of Breast / CIS of Cervix<br>(a) Dates and results of the latest and all previous Pap Smear tests (please provide copy of cytology reports) *Applicable to CIS of Cervix only<br>(b) Dates & results of the biopsy or cone or colposcopy with cervical biopsy (please provide copy of stopathology reports)<br>(c) (i) When did the Person Covered previously receive treatment for CIS of Breast / CIS of Cervix for an abnormal smear?<br>(ii) From whom/where? | 8.<br>(a) _____ (MM/DD/YYYY)<br>(b) _____ (MM/DD/YYYY)<br>(c) (i) _____ (MM/DD/YYYY)<br>(ii) _____<br>_____ |
| 9. Is the condition malignant? | 9. ☐ Yes ☐ No |
| 10. Is there focal autonomous new growth of carcinomatous cells? | 10. ☐ Yes ☐ No |
| 11. (a) Is there invasion of normal tissues by the carcinomatous cells?<br>(b) If "Yes", what is the stage of the invasion? | 11. (a) ☐ Yes ☐ No<br>(b) _____ |
| 12. (a) Details with dates of medical treatment performed as well as current medication.<br>(b) Was there any surgery performed?<br>(c) If "Yes", please provide details of surgical procedure(s). | 12. (a) _____ (MM/DD/YYYY)<br>(b) ☐ Yes ☐ No<br>(c) _____ |
| 13. Present condition of the Person Covered. | 13. _____ |
| 14. Prognosis. | 14. _____ |
| 15. Is the Person Covered HIV (Human Immunodeficiency Virus)positive? | 15. ☐ Yes ☐ No |
| 16. Was the Person Covered treated by any other doctors or hospitals? If "Yes", please provide us the dates, names and addresses of the doctors / hospitals. | 16. ☐ Yes ☐ No<br>_____<br>_____ |
| 17. Has the Person Covered suffered from / been treated for any other illnesses or complaints other than this condition?<br>If "Yes", please provide full details. | 17. ☐ Yes ☐ No<br>_____<br>_____ |
| 18. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information. | 18. ☐ Yes ☐ No<br>_____<br>_____ |

I hereby certify that I have personally examined and treated the Person Covered 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) (MM/DD/YYYY)

_____

Contact No.: _____