AIA PUBLIC TAKAFUL

ATTENDING PHYSICIAN'S STATEMENT

Critical Illness – Chronic Aplastic Anaemia

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? (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) ______________________ (MM/DD/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 Person Covered 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) ______________________ (MM/DD/YYYY) (ii) ______________________ (iii) ______________________
4. (a) On what date was the diagnosis made? (b) On what date was the Person Covered first made aware of it?	4. (a) ______________________ (MM/DD/YYYY) (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 : ______________________

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Part II - Details of the Person Covered's Illness

Question	Answer
1. Please provide full and exact details of the diagnosis.	1. ______
2. Please describe the extent of the disease. (a) Date of the diagnosis. (b) What is the diagnosis? (c) Is bone marrow biopsy to confirm diagnosis?	2. (a) ______ (MM/DD/YYYY) (b) ______ (c) ☐ Yes ☐ No
3. What are the haemoglobin level, red cell count, white cell count and platelet count?	3. ______
4. What are the nature of treatment? (a) blood product transfusion (b) marrow stimulating agents (c) immunosuppresive agents (d) bone marrow transplantation	4. (a) ☐ Yes ☐ No (b) ☐ Yes ☐ No (c) ☐ Yes ☐ No (d) ☐ Yes ☐ No
5. 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.	5. ☐ Yes ☐ No ______
6. Has the Person Covered suffered from/been treated for any other illnesses or complaints other than this Critical Illness? If "Yes", please give full details.	6. ☐ Yes ☐ No ______
7. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.	**7.** ______

Note: Please enclose copies of all reports, bone marrow, radiological procedure, CT scans, and laboratory evidence, other imaging procedures, etc. and any relevant reports that are available.

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.

______
Signature of Attending Physician

Qualification: ______

Name & Address: ______
(Official Stamp)
______

Date: ______
(MM/DD/YYYY)

Contact No.: ______