AIA PUBLIC TAKAFUL

ATTENDING PHYSICIAN'S STATEMENT
Critical Illness – End Stage Kidney Failure
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 : _____

Part II - Details of the Person Covered's Illness

1. Please provide full and exact details of the diagnosis, leading to chronic renal failure, including dates of diagnosis of said impairments.	1. _____ _____
2. Please describe the extent of the kidney failure. (a) (i) Has the Person Covered's renal disease reached end-stage? (ii) If "Yes", please state the date. (b) Are both kidneys involved? (c) (i) Is the Person Covered undergoing regular peritoneal dialysis or haemodialysis? (ii) If "Yes", please state the date. (d) (i) Has renal transplantation been performed? (ii) If "Yes", please state the date.	2. (a) (i) ☐ Yes ☐ No (ii) _____(MM/DD/YYYY) (b) ☐ Yes ☐ No (c) (i) ☐ Yes ☐ No (ii) _____(MM/DD/YYYY) (d) (i) ☐ Yes ☐ No (iii) _____(MM/DD/YYYY)
3. 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.	3. ☐ Yes ☐ No _____ _____ _____ _____
4. Has the Person Covered suffered from / been treated for any other illnesses or complaints other than this Critical Illness? If "Yes", please provide full details.	4. ☐ Yes ☐ No _____ _____ _____ _____
5. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.	5. _____ _____ _____ _____

Note: Please enclose copies of all reports including kidney function test, ultrasound, MRI, and other imaging studies, laboratory evidence, dialysis receipts / card 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.: _____