AIA PUBLIC TAKAFUL

ATTENDING PHYSICIAN'S STATEMENT

Critical Illness - Stroke

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

Question	Answer
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?

Factor		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.	1. ______________________ ______________________ ______________________
2. Please describe the initial episode. (a) Date of the Episode. (b) Nature of the Episode. (c) Duration of the Acute Symptoms. (d) Date of Return to Normal Activities and / or the Person Covered's Physical and Mental capabilities. (e) Date of last consultation.	2. (a) ______________________ (MM/DD/YYYY) (b) ______________________ (c) ______________________ (d) ______________________ (MM/DD/YYYY) (e) ______________________ (MM/DD/YYYY)
3. Did the Person Covered suffer from a neurological sequalae which lasted more than 24 hours or lasted more than 3 months or lasted more than 6 months? Please tick the relevant. (b) Please comment on any neurological sequela which had lasted as per the above time frame. (c) Are these sequela permanent?	3. (a) ☐ Lasted more than 24 hours or ☐ Lasted more than 3 months or ☐ Lasted more than 6 months (b) ______________________ (c) ☐ Yes ☐ No
4. Has there been an infarction of brain tissue cerebral haemorrhage or embolization from an extracranial source?	4. ☐ 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 provide 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, radiological procedures, CT scans, laboratory tests, 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.: ______________________