



**ATTENDING PHYSICIAN'S STATEMENT**

**Critical Illness – Parkinson's Disease or Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders**

To be completed by Registered Medical Practitioner at Assured's / Claimant's own expense

Policy No.	NRIC No.	Age																														
Name of Assured		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female																														
<b>Note – Please tick the relevant diagnosis</b> <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders																																
<b>I) General Information</b>																																
1. (a) Are you the Assured's usual medical physician?  (b) If "Yes", over what period do your records extend?	1. (a) <input type="checkbox"/> Yes <input type="checkbox"/> 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) _____ (DD/MM/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 Assured 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) <input type="checkbox"/> Yes <input type="checkbox"/> No  (b) _____ _____ (c) <input type="checkbox"/> Yes <input type="checkbox"/> No (i) _____ (DD/MM/YYYY) (ii) _____ (iii) _____																															
4. (a) On what date was the diagnosis made?  (b) On what date was the Assured first made aware of it?	4. (a) _____ (DD/MM/YYYY) (b) _____ (DD/MM/YYYY)																															
5. Please state if there is anything in the Assured's family history which would have increased the risk of this illness.	5. _____ _____																															
6. Which of the following factors are present?  a) Past history of controlled hypertension b) Past history of uncontrolled hypertension c) Diabetes Mellitus d) Obesity e) Chronic smoker f) Heavy drinker g) Stress h) Hyperlipidaemia i) Others, please specify : _____	<table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:70%;"></th> <th style="width:10%; text-align: center;">Yes / No</th> <th style="width:20%; text-align: center;">Date of Onset (DD/MM/YYYY)</th> </tr> </thead> <tbody> <tr><td>a)</td><td style="text-align: center;">Yes / No</td><td>_____</td></tr> <tr><td>b)</td><td style="text-align: center;">Yes / No</td><td>_____</td></tr> <tr><td>c)</td><td style="text-align: center;">Yes / No</td><td>_____</td></tr> <tr><td>d)</td><td style="text-align: center;">Yes / No</td><td>_____</td></tr> <tr><td>e)</td><td style="text-align: center;">Yes / No</td><td>_____</td></tr> <tr><td>f)</td><td style="text-align: center;">Yes / No</td><td>_____</td></tr> <tr><td>g)</td><td style="text-align: center;">Yes / No</td><td>_____</td></tr> <tr><td>h)</td><td style="text-align: center;">Yes / No</td><td>_____</td></tr> <tr><td>i)</td><td style="text-align: center;">Yes / No</td><td>_____</td></tr> </tbody> </table>			Yes / No	Date of Onset (DD/MM/YYYY)	a)	Yes / No	_____	b)	Yes / No	_____	c)	Yes / No	_____	d)	Yes / No	_____	e)	Yes / No	_____	f)	Yes / No	_____	g)	Yes / No	_____	h)	Yes / No	_____	i)	Yes / No	_____
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<b>II) Details of the Assured's Illness</b>	
1. Please provide full and exact details of the diagnosis.	1. _____ _____
2. Please describe the extent of the disease (i) Parkinson's Disease (a) When was the date of onset? (b) What is the diagnosis? (c) What is the cause of the disease?  (ii) Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders (a) Is there evidence of deterioration or loss of Intellectual capacity or abnormal behaviour resulting in significant reduction in mental and social functioning requiring continuous supervision of the life Assured? If "Yes", please describe the findings.  (b) Is the deterioration or loss of intellectual capacity or abnormal behaviour arise from neurosis, psychiatric, illness, any drug or alcohol related organic disorder? If "Yes", please give details.	2. _____ (i) (a) _____ (DD/MM/YYYY) (b) _____ (c) _____  (ii) (a) <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____  (b) <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____
3. Is the Assured able to perform the following without assistance? (a) Getting in and out of a chair without requiring physical assistance. (b) The ability to move from room to room without requiring any physical assistance. (c) The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene (d) Putting on and taking off all necessary items of clothing without requiring assistance of another person. (e) The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means. (f) All tasks of getting food into the body once it has been prepared.	3. _____ (a) <input type="checkbox"/> Yes <input type="checkbox"/> No (b) <input type="checkbox"/> Yes <input type="checkbox"/> No (c) <input type="checkbox"/> Yes <input type="checkbox"/> No (d) <input type="checkbox"/> Yes <input type="checkbox"/> No (e) <input type="checkbox"/> Yes <input type="checkbox"/> No (f) <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has the Assured suffered from / been treated for any other illnesses or complaints other than this Critical Illness? If "Yes", please provide full details.	4. <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____
5. Was the Assured treated by any other doctors or hospitals? If "Yes", please provide us the dates, names and addresses of the doctors / hospitals.	5. <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____
6. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.	6. _____ _____
<b>Note:</b> (i) For Parkinson's Disease claims, please enclose copies of all neurological reports, X-rays, CT scans, and other imaging studies, laboratory evidence, cerebral angiogram and any relevant reports that is available. (ii) For Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders claims, please enclose copies of questionnaires or test reports or any relevant hospital reports that are available.	
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.	
Signature of Attending Physician _____	Qualification _____
Name & Address _____ (Official Stamp)	Date _____ (DD/MM/YYYY)
Contact No. _____	