


**AIA PUBLIC
TAKAFUL**
ATTENDING PHYSICIAN'S STATEMENT
Critical Illness – Encephalitis or Bacterial Meningitis
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: <input type="checkbox"/> Male <input type="checkbox"/> 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) <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) _____ (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) <input type="checkbox"/> Yes <input type="checkbox"/> No (b) _____ _____ (c) <input type="checkbox"/> Yes <input type="checkbox"/> 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. _____ _____																															
<table border="0" style="width: 100%;"> <tr> <td style="width: 40%;">6. Which of the following factors are present?</td> <td style="width: 10%;"></td> <td style="width: 50%;">Date of Onset (MM/DD/YYYY)</td> </tr> <tr> <td>a) Past history of controlled hypertension</td> <td>Yes / No</td> <td>_____</td> </tr> <tr> <td>b) Past history of uncontrolled hypertension</td> <td>Yes / No</td> <td>_____</td> </tr> <tr> <td>c) Diabetes Mellitus</td> <td>Yes / No</td> <td>_____</td> </tr> <tr> <td>d) Obesity</td> <td>Yes / No</td> <td>_____</td> </tr> <tr> <td>e) Chronic smoker</td> <td>Yes / No</td> <td>_____</td> </tr> <tr> <td>f) Heavy drinker</td> <td>Yes / No</td> <td>_____</td> </tr> <tr> <td>g) Stress</td> <td>Yes / No</td> <td>_____</td> </tr> <tr> <td>h) Hyperlipidaemia</td> <td>Yes / No</td> <td>_____</td> </tr> <tr> <td colspan="3">i) Others, please specify : _____</td> </tr> </table>			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

<p>1. Please provide full and exact details of the diagnosis.</p>	<p>1. _____</p> <p>_____</p>
<p>2. Please describe the extent of the illness (where applicable).</p> <p>(i) Encephalitis or Bacterial meningitis</p> <p>(a) Date of the Diagnosis</p> <p>(b) When was the Person Covered informed of the diagnosis?</p> <p>(c) Please state the date of the Person Covered's return to normal activities and/or the Person Covered's present physical and mental limitation.</p> <p>(d) Was there any significant and serious permanent neurological deficit?</p> <p>(e) Is the permanent neurological deficit</p> <p>(i) documented for more than 30 days?</p> <p>(ii) resulting in any inability to perform at least three (3) of the Activities of Daily living?</p> <p>(f) Which of the following daily activities is the Person Covered NOT able to perform? Please check the appropriate item.</p> <p>(g) Is such inability expected to be permanent?</p> <p>(h) Is the Person Covered HIV positive?</p> <p>(i) For bacterial meningitis, is there a presence of bacterial infection in the cerebrospinal fluid by lumbar puncture?</p>	<p>2.</p> <p>(i) _____ (MM/DD/YYYY)</p> <p>(d) _____ (MM/DD/YYYY)</p> <p>(c) _____ (MM/DD/YYYY)</p> <p>(d) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(e)</p> <p>(i) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(ii) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(f)</p> <p><input type="checkbox"/> Getting in and out of a chair without requiring physical assistance.</p> <p><input type="checkbox"/> The ability to move from room to room without requiring any physical assistance.</p> <p><input type="checkbox"/> The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene.</p> <p><input type="checkbox"/> Putting on and taking off all necessary items of clothing without requiring assistance of another person.</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> All tasks of getting food into the body once it has been prepared.</p> <p>(g) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(h) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(i) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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.</p>	<p>3. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>_____</p> <p>_____</p>
<p>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.</p>	<p>4. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>_____</p> <p>_____</p>
<p>5. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.</p>	<p>5. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>_____</p> <p>_____</p>

Note: Please enclose copies of all reports including X-rays, CT scan, blood test, other laboratory tests, cytology, surgical report and any relevant hospital 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.: