ATTENDING PHYSICIAN'S STATEMENT

Critical Illness – AIDS Due to Blood Transfusion / Occupationally Acquired Human Immunodeficiency Virus (HIV) Infection

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

Policy No.	NRIC No.	Age
Name of Assured		Sex ☐ Male ☐ Female

I) General Information

1. (a) Are you the Assured'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) _____ (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) ☐ Yes ☐ No (b) _____ (c) ☐ Yes ☐ 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?

		Date of Onset (DD/MM/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 : _____

_____

II) Details of the Assured's Illness

1. Please provide full and exact details of the diagnosis.	1. _____ _____
2. Please describe the cause of infection. A. AIDS due to Blood Transfusion	2. A.
a. (i) Was the infection due to blood transfusion?	a (i) ☐ Yes ☐ No
(ii) Was the blood transfusion medically necessary or given as part of medical treatment?	(ii) ☐ Yes ☐ No
(iii) Was the blood transfusion received in Malaysia or Singapore?	(iii) ☐ Yes ☐ No
(iv) Was the infection resulted from any other means including sexual activity and the use of intravenous drugs?	(iv) ☐ Yes ☐ No
b. (i) Is the source of infection established from the institution that provided the blood transfusion?	b (i) ☐ Yes ☐ No
(ii) Is the institution able to trace the origin of the HIV tainted blood?	(ii) ☐ Yes ☐ No
c. Is the patient suffering from Thalassaemia Major or Haemophilia?	c. ☐ Yes ☐ No
d. Was an HIV antibody test done before the blood transfusion?	d. ☐ Yes ☐ No
If "Yes", what was the result?	_____
B. Occupationally Acquired HIV Infection a. Is the Assured a medical staff working in Malaysia?	B. a. ☐ General Physician ☐ Specialist ☐ Nurse ☐ Laboratory Technician
If "Yes", please check the appropriate item.	☐ Dentist ☐ Ambulance Worker of medical centre, hospital or dental clinic/polyclinic
b. Please state the Assured's normal occupational duties.	b. _____
c. Is the HIV infection acquired as a result of an accident occurring during the course of carrying out normal occupational duties?	c. ☐ Yes ☐ No
d. For Accident case, please state below:	d.
(i) Date of Accident	(i) _____ (DD/MM/YYYY)
(ii) Place of Accident	(ii) _____
(iii) How did the Accident happen?	(iii) _____
e. (i) Was there a HIV test carried out?	e. (i) ☐ Yes ☐ No
(ii) Date of HIV test taken	(ii) _____ (DD/MM/YYYY)
f. Was the HIV infection as a result of sexual activity, blood transfusions or recreational intravenous drug use?	f. ☐ Yes ☐ No
3. Was the Assured treated by any other doctors or hospitals? If "Yes", please provide us the dates, names and addresses of the doctors / hospitals.	3. _____ _____
4. Has the Assured suffered from/been treated for any other illnesses or complaints other than this Critical Illness? If "Yes", please give full details.	4. _____ _____
5. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.	5. _____ _____

Note: For AIDS due to blood transfusion or Occupationally Acquired Human Immunodeficiency Virus (HIV) Infection claim, please enclose copies of all blood test done, HIV profile test, chest X-ray, laboratory test study, etc and any relevant 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.

_____ Qualification _____

Signature of Attending Physician

Name & Address _____ Date _____

(Official Stamp) (DD/MM/YYYY)

_____

Contact No. _____