



ATTENDING PHYSICIAN'S STATEMENT

Critical Illness - Coma

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																																	
I) General Information																																			
<p>1. (a) Are you the Assured's usual medical physician? (b) If "Yes", over what period do your records extend?</p>	<p>1. (a) <input type="checkbox"/> Yes <input type="checkbox"/> No (b) _____ _____</p>																																		
<p>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?</p>	<p>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</p>																																		
<p>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.</p>	<p>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) _____</p>																																		
<p>4. (a) On what date was the diagnosis made? (b) On what date was the Assured first made aware of it?</p>	<p>4. (a) _____ (DD/MM/YYYY) (b) _____ (DD/MM/YYYY)</p>																																		
<p>5. Please state if there is anything in the Assured's family history which would have increased the risk of this illness.</p>	<p>5. _____ _____</p>																																		
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:40%;"></td> <td style="width:20%; text-align: center;">Date of Onset (DD/MM/YYYY)</td> <td style="width:40%;"></td> </tr> <tr> <td style="padding: 2px;">6. Which of the following factors are present?</td> <td></td> <td></td> </tr> <tr> <td style="padding: 2px;">a) Past history of controlled hypertension</td> <td style="padding: 2px;">Yes / No</td> <td style="padding: 2px;">_____</td> </tr> <tr> <td style="padding: 2px;">b) Past history of uncontrolled hypertension</td> <td style="padding: 2px;">Yes / No</td> <td style="padding: 2px;">_____</td> </tr> <tr> <td style="padding: 2px;">c) Diabetes Mellitus</td> <td style="padding: 2px;">Yes / No</td> <td style="padding: 2px;">_____</td> </tr> <tr> <td style="padding: 2px;">d) Obesity</td> <td style="padding: 2px;">Yes / No</td> <td style="padding: 2px;">_____</td> </tr> <tr> <td style="padding: 2px;">e) Chronic smoker</td> <td style="padding: 2px;">Yes / No</td> <td style="padding: 2px;">_____</td> </tr> <tr> <td style="padding: 2px;">f) Heavy drinker</td> <td style="padding: 2px;">Yes / No</td> <td style="padding: 2px;">_____</td> </tr> <tr> <td style="padding: 2px;">g) Stress</td> <td style="padding: 2px;">Yes / No</td> <td style="padding: 2px;">_____</td> </tr> <tr> <td style="padding: 2px;">h) Hyperlipidaemia</td> <td style="padding: 2px;">Yes / No</td> <td style="padding: 2px;">_____</td> </tr> <tr> <td style="padding: 2px;">i) Others, please specify : _____</td> <td></td> <td></td> </tr> </table>				Date of Onset (DD/MM/YYYY)		6. Which of the following factors are present?			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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