



**ATTENDING PHYSICIAN'S STATEMENT**

**Critical Illness - Coronary Artery Disease Requiring Surgery/Other Serious Coronary Artery Disease/ Angioplasty/Heart Attack**  
**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
<input type="checkbox"/> <b>Coronary Artery Disease Requiring Surgery</b>		
<input type="checkbox"/> <b>Heart Attack</b>		
<input type="checkbox"/> <b>Other Serious Coronary Artery Disease</b>		
<input type="checkbox"/> <b>Angioplasty and Other Invasive Treatments for Coronary Artery Disease</b>		

**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>

<p>6. Which of the following factors are present?</p> <p>a) Past history of controlled hypertension</p> <p>b) Past history of uncontrolled hypertension</p> <p>c) Diabetes Mellitus</p> <p>d) Obesity</p> <p>e) Chronic smoker</p> <p>f) Heavy drinker</p> <p>g) Stress</p> <p>h) Hyperlipidaemia</p> <p>i) Others, please specify : _____</p>	<p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p>	<p>Date of Onset (DD/MM/YYYY)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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II) Details of the Assured's Illness	
1. Please provide full and exact details of the diagnosis.	1. _____ _____
2.. Please describe the extent of the disease. (a) Which arteries are involved and what is the degree of narrowing (%) in respect of each involved artery? (b) Was coronary arteriography performed?	2. _____ (a) _____ (b) <input type="checkbox"/> Yes    Date Performed _____ (DD/MM/YYYY) <input type="checkbox"/> No
3. What is the nature of treatment? (a) Was open heart surgery performed? (b) If "Yes", state the number and sites of grafts inserted. (c) Was balloon angioplasty, atherectomy or laser treatment done? If "Yes", please state which treatment was done. (d) What other forms of treatment were rendered (if any)?	3. _____ (a) <input type="checkbox"/> Yes    Date Performed _____ (DD/MM/YYYY) <input type="checkbox"/> No (b) _____ (c) <input type="checkbox"/> Yes    Date Performed _____ (DD/MM/YYYY) <input type="checkbox"/> No Treatment _____ (d) _____ Date _____ (DD/MM/YYYY)
4. Please describe the Heart Attack (For Heart Attack) (a) Date of Attack. (b) Was there a history of typical prolonged chest pain? (c) Was there a serial elevation of cardiac enzymes (CPK -MB) documented. (d) Were there any changes in ECG indicative of a myocardial infarction from this occurrence? (e) Troponin T > 1.0 ng/ml or equivalent threshold with other Troponin I methods? (f) Duration of the Acute Symptoms. (g) Date of Return to Normal Activities and/or the Assured's Present Limitations Physical and Mental	4. _____ (DD/MM/YYYY) (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) _____ (g) _____ (DD/MM/YYYY)
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. Has the Assured suffered from / been treated for any other illnesses or complaints other than this Critical Illness? If "Yes", please provide details.	6. <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____
7. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.	7. <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____

**Note:** Please enclose copies of post bypass report, angiograms, Post Percutaneous Transluminal Coronary Angioplasty (PTCA), ECGs, Cardiac Enzymes assays, Troponin T test, Echocardiogram and all reports including X-rays, CT scans, any other imaging studies, laboratory evidence, etc. and 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. _____	