



**ATTENDING PHYSICIAN'S STATEMENT**

**Critical Illness – Loss of Independent Existence**

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>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;">_____</td><td style="text-align: center;">_____</td></tr> <tr><td>b)</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td></tr> <tr><td>c)</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td></tr> <tr><td>d)</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td></tr> <tr><td>e)</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td></tr> <tr><td>f)</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td></tr> <tr><td>g)</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td></tr> <tr><td>h)</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td></tr> <tr><td>i)</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td></tr> </tbody> </table>			Yes / No	Date of Onset (DD/MM/YYYY)	a)	_____	_____	b)	_____	_____	c)	_____	_____	d)	_____	_____	e)	_____	_____	f)	_____	_____	g)	_____	_____	h)	_____	_____	i)	_____	_____
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f)	_____	_____																														
g)	_____	_____																														
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i)	_____	_____																														
7. Please give below, the details of any other doctors or specialists the Assured has consulted in connection with this illness.																																
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(b) _____	_____	_____																														

<b>II) Details of the Assured's Illness</b>										
1. Please provide full and exact details of the diagnosis.	1. _____ _____									
2. Investigations Done.	2. <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"><u>Dates (DD/MM/YYYY)</u></td> <td style="width: 40%;"><u>Procedures</u></td> <td style="width: 30%;"><u>Results</u></td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table>	<u>Dates (DD/MM/YYYY)</u>	<u>Procedures</u>	<u>Results</u>	_____	_____	_____	_____	_____	_____
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_____	_____	_____								
_____	_____	_____								
3. (a) Details of Treatment Rendered.  (b) Was there any surgery performed?  (c) If "Yes", please provide details of surgical procedures.  (d) Last Date of Consultation	3. (a) _____ _____ (b) <input type="checkbox"/> Yes <input type="checkbox"/> No (c) _____ (d) _____(DD/MM/YYYY)									
5. If the Assured is not bedridden, which of the following daily activities is the Assured NOT able to perform as a direct result of the trauma? Please check the appropriate item.      (b) Is such inability expected to be permanent?	4. (a) <input type="checkbox"/> Getting in and out of a chair without requiring physical assistance. <input type="checkbox"/> The ability to move from room to room without requiring any physical assistance. <input type="checkbox"/> The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene <input type="checkbox"/> Putting on and taking off all necessary items of clothing without requiring assistance of another person. <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. <input type="checkbox"/> All tasks of getting food into the body once it has been prepared.  (b) <input type="checkbox"/> Yes <input type="checkbox"/> No									
5. Prognosis	5. _____									
6. Has the Assured suffered from / been treated for any other illnesses or complaints other than this Critical Illness? If "Yes", please provide full details.	6. <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____									
7. Was the Assured treated by any other doctors or hospitals? If "Yes", please provide us the dates, names and addresses of the doctors / hospitals.	7. <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____									
8. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.	8. _____ _____									
<b>Note:</b> Please enclose copies of all reports including biopsy, cytology reports, X-rays, CT scans, other imaging studies, laboratory evidence, surgical report, 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. _____										