



**ATTENDING PHYSICIAN'S STATEMENT**

**Critical Illness – Paralysis / Paraplegia**

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>																																
<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>	<table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:60%;"></th> <th style="width:10%; text-align: center;">Yes / No</th> <th style="width:30%; text-align: center;">Date of Onset (DD/MM/YYYY)</th> </tr> </thead> <tbody> <tr> <td>a) Past history of controlled hypertension</td> <td style="text-align: center;">Yes / No</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>b) Past history of uncontrolled hypertension</td> <td style="text-align: center;">Yes / No</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>c) Diabetes Mellitus</td> <td style="text-align: center;">Yes / No</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>d) Obesity</td> <td style="text-align: center;">Yes / No</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>e) Chronic smoker</td> <td style="text-align: center;">Yes / No</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>f) Heavy drinker</td> <td style="text-align: center;">Yes / No</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>g) Stress</td> <td style="text-align: center;">Yes / No</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>h) Hyperlipidaemia</td> <td style="text-align: center;">Yes / No</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>i) Others, please specify : _____</td> <td></td> <td></td> </tr> </tbody> </table>			Yes / No	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 : _____		
	Yes / No	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 extent of the disease.  
 (a) When was the date of the onset? (a) \_\_\_\_\_ (DD/MM/YYYY)  
 (b) The Areas of Involvement (b) \_\_\_\_\_  
 (c) (i) Is the loss of use of the involved limbs considered complete and permanent? (c) (i)  Yes  No  
 (ii) If "Yes", please provide bases for prognosis. (ii) \_\_\_\_\_  
 (d) Date of last consultation. (d) \_\_\_\_\_ (DD/MM/YYYY)

3. What is the cause of the paralysis? 3. \_\_\_\_\_

4. Was the Assured treated by any other doctors or hospitals? If "Yes", please provide us the dates, names and addresses of the doctors / hospitals. 4.  Yes  No  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

5. Has the Assured suffered from / been treated for any other illnesses or complaints other than this Critical Illness? If "Yes", please provide full details. 5.  Yes  No  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

6. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information. 6.  Yes  No  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Note:** Please enclose copies of all neurological reports, X-rays, CT scans, MRI and any other imaging studies, laboratory tests, surgical reports, 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.

\_\_\_\_\_  
 Signature of Attending Physician Qualification \_\_\_\_\_

Name & Address \_\_\_\_\_ Date \_\_\_\_\_  
 (Official Stamp) (DD/MM/YYYY)

Contact No. \_\_\_\_\_