

ATTENDING PHYSICIAN'S STATEMENT

Critical Illness - Stroke
To be completed by Registered Medical Practitioner at Assured's / Claimant's own expense

See Mate Female	Policy No.					NRIC No.					Age	
1. (a) Ave you the Assured's usual medical physician? (b) If Yos', over what period do your records extend? 2. (a) When were you first consulted for this illness? (b) What were the symptomscomplaints existed: (c) How long had the symptomscomplaints existed: (d) According to the patient? (e) In your medical opinion? 2. (a) Has the Assured previously suffered from this illness or any related illnesses? (b) If Yes', please give dates of consultations and the reveiling diagnosis. (c) Was the patient referred to you? (d) If Yes, when? (e) Neasons for referral? (ii) Ame and address of the referral doctors. 4. (a) On what date was the diagnosis made? (b) On what date was the diagnosis made? (c) On what date was the diagnosis made? (d) On what date was the Assured first made aware of it? 5. Please state if there is anything in the Assured's family history which would have increased the risk of this illness. 6. Which of the following factors are present? a) Past history of controlled hypertension b) Past history of controlled hypertension C) Diabotes Melitus C) Cheetiy C) Cherric smoker C) Heavy diricker C) Colombia Myryyy C) Cherric smoker C) Heavy diricker C) Colombia C) Stress C) No C) Cherric smoker C) Colombia C) Colomb	Name of Assured									Sex	Male	Female
(b) H*Yes*, over what period do your records extend? (c) When were you first consulted for this liness? (d) What were the symptoms/complaints existed: (i) According to the patient? (ii) In your medical opinion? (c) In your medical opinion? (d) According to the patient? (iii) In your medical opinion? (iv) What she Assured previously suffered from this liness or any related illnesses? (iv) H*Yes*; please give dates of consultations and the resulting diagnosis. (c) Was the patient referred to you? (ii) If Yes, when? (iii) Name and address of the referral doctors. (iv) On what date was the diagnosis made? (iv	I) General Information											
(b) What were the symptoms/complaints? (c) How long had the symptoms/complaints existed (i) According to the patient? (ii) In your medical opinion? (ii) Day/s Week/s Month/s Year/s (iii) Day/s Week/s Month/s Year/s (iii) Day/s Week/s Month/s Year/s 3. (a) Has the Assured previously suffered from this liness or any related tilinesses? (b) If Yes', please give dates of consultations and the resulting diagnosis. (c) Was the patient referred to you? (ii) Yes, when? (iii) Reasons for referral? (iii) Name and address of the referral doctors. 4. (a) On what date was the diagnosis made? (b) On what date was the Assured first made avaire of It? 5. Please state if there is anything in the Assured's family history which would have increased the risk of this illness. 6. Which of the following factors are present? a) Past history of controlled hypertension Ves / No D) Past history of uncontrolled hypertension Yes / No O) Disabetes Mellitus Yes / No O) Chronic smoker Yes / No O) Chronic smoker Yes / No O) Stress Yes / No O) Stress Yes / No O) Hyperfipidaemia Yes / No O) Hyperfipidaemia	1.	(b) If "Yes", over what period do your records	1.									
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. (b)	2.	(b) What were the symptoms/complaints?(c) How long had the symptoms/complaints existed :- (i) According to the patient?	2.	(b)	(i)	Day	//s		Week/s		_ Month/s	Year/s
(iii) Name and address of the referral doctors. (iii)	3.	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?	3.	(b)	Yes	□ No						(DD/MM/YYYY)
(b) On what date was the Assured first made aware of it? Date of Onset (DD/MM/YYYY)		•										
family history which would have increased the risk of this illness. Date of Onset (DD/MM/YYYY)	4.	(b) On what date was the Assured first made	4.									
a) Past history of controlled hypertension b) Past history of uncontrolled hypertension c) Diabetes Mellitus Yes / No d) Obesity Yes / No e) Chronic smoker f) Heavy drinker g) Stress Yes / No h) Hyperlipidaemia Yes / No	5.	family history which would have increased the risk	5.									
	6.	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	Yes Yes Yes Yes Yes Yes Yes	/ No / No / No / No / No / No								

II) Details of the Assured's Illness											
1.	Please provide full and exact details of the diagnosis.	1.									
2.	Please describe the initial episode.	2.									
	(a) Date of the Episode.		(a)				(DD/MM/YYYY)				
	(b) Nature of the Episode.		(b)								
	(c) Duration of the Acute Symptoms.		(c)								
	(d) Date of Return to Normal Activities and / or the Assured's Physical and Mental capabilities.		(d)				(DD/MM/YYYY)				
	(e) Date of last consultation.		(e)				(DD/MM/YYYY)				
3.	Did the Assured suffer from a neurological sequalae which lasted more than 24 hours or lasted more than 3 months or lasted more than 6 months? Please tick the relevant.	3.	(a)		Lasted more than 24 ho Lasted more than 3 more Lasted more than 6 more	nths or					
	(b) Please comment on any neurological sequela which had lasted as per the above time frame.		(b)								
	(c) Are these sequela permanent?		(c)	Yes	No						
4.	Has there been an infarction of brain tissue cerebral haemorrhage or embolization from an extracranial source?	4.		Yes	No						
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.		Yes	□ No						
Has the Assured suffered from / been treated for any other illnesses or complaints other than this Critical Illness? If "Yes", please provide full details.				Yes	□ No						
7.	If there is any further information which in your opinion	7.									
	will assist us in assessing this claim, please furnish such information.										
No	Note: Please enclose copies of all reports, radiological procedures, CT scans, laboratory tests, other imaging procedures, 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.											
Signature of Attending Physician Qualification											
Name & Address Date											
(Of	icial Stamp)						(DD/MM/YYYY)				
Coi	ntact No.										