



ATTENDING PHYSICIAN'S STATEMENT

Critical Illness & Female Product– Systemic Lupus Erythematosus (S.L.E) with Lupus Nephritis

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		
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) Has S.L.E been definitely diagnosed? (b) On what date was the diagnosis made? (c) On what date was the Assured first made aware of it?	4. (a) <input type="checkbox"/> Yes <input type="checkbox"/> No (b) _____ (DD/MM/YYYY) (c) _____ (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. Other physicians or medical facilities the Assured has consulted for this condition. _____		
7. Which of the following factors are present?	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 : _____		

8. Please confirm which of the following clinical manifestations is exhibited by the Assured.

	Yes	No		Yes	No		Yes	No
Malar rash	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Lymphopenia [$<1,500/\mu\text{L}$]	<input type="checkbox"/>	<input type="checkbox"/>
Discoid rash	<input type="checkbox"/>	<input type="checkbox"/>	Serositis	<input type="checkbox"/>	<input type="checkbox"/>	Haemolytic anemia	<input type="checkbox"/>	<input type="checkbox"/>
Photosensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Renal disorder	<input type="checkbox"/>	<input type="checkbox"/>	Thrombocytopenia [$<100,000/\mu\text{L}$]	<input type="checkbox"/>	<input type="checkbox"/>
Oral ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Leukopenia [$<4,000/\mu\text{L}$]	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorder	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify) _____								

9. What is the nature and extent of cardiac, central nervous stem and renal impairment?

10. Results & dates of following laboratory test (please provide copy of test results).

	<u>Results</u>	<u>Dates (DD/MM/YYYY)</u>
Anti-Nuclear Antibodies	_____	_____
L.E. Cells	_____	_____
Anti-Sm	_____	_____
Anti-DNA	_____	_____
Creatinine Clearance Rate	_____	_____
Post record	_____	_____
Latest record	_____	_____

11. Date and result of renal biopsy.

12. Results of other investigations, e.g. biopsy, renal functions test, etc. (please provide copy of test results).

13. Details of treatment rendered.

Was there any surgery performed? If "Yes", please provide details of surgical procedures Yes No

14. Present Condition of the Assured

15. Prognosis

16. Please state if the Assured has previously suffered / been treated for any other illnesses / complaints other than this condition.

17. Please confirm if Assured falls within either Type III to Type IV Lupus Nephritis. If yes, please specify type and degree of impairment.

18. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.

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.