ATTENDING PHYSICIAN'S STATEMENT
Female Product– Disseminated Intravascular Coagulation (D.I.C.)
To be completed by Registered Medical Practitioner at Assured's / Claimant's own expense

Policy No.	NRIC No.	Age
Name of Assured	Sex ☐ Male ☐ 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) ☐ Yes ☐ 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) ☐ Yes ☐ No (b) _____ (c) ☐ Yes ☐ 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. Other physicians or medical facilities the Assured has consulted in connection with this illness.

Names of Physicians / Facilities	Addresses	Dates of Consultations / Confinement Periods

7. How long has the condition been medically documented?

_____

_____

8. Was there entrance of uterine material with tissue factor activity into the maternal circulation?	8. _____
9. Has this resulted in major haemorrhage?	9. _____
10. Was the D.I.C. resulted from Abortion?	10. ☐ Yes ☐ No
11. How many weeks of pregnancy currently?	11. _____
12. Does this require treatment with frozen plasma and platelet concentrates? Please give details of treatment.	12. _____
13. Present Condition of the Assured.	13. _____
14. Prognosis.	14. _____
15. Please state if the Assured suffered from / been treated for any other illnesses or complaints other than this condition.	15. _____
16. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.	16. _____

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.

_____ Qualification _____

Signature of Attending Physician

Name & Address _____ Date _____

(Official Stamp)

(DD/MM/YYYY)

_____

Contact No. _____