



**ATTENDING PHYSICIAN'S STATEMENT**

**Female Product- Down's Syndrome**

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. When were you first consulted for this conditions?	2. _____ (DD/MM/YYYY)	
3. Is there an extra chromosome 21?	3. <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Does the Assured exhibit (a) muscular hypotonicity? (b) microcephaly? (c) brachycephaly? (d) flattened occiput?	4. (a) <input type="checkbox"/> Yes <input type="checkbox"/> No (b) <input type="checkbox"/> Yes <input type="checkbox"/> No (c) <input type="checkbox"/> Yes <input type="checkbox"/> No (d) <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. What is the nature and extent of retardation of physical and mental development?	5. _____ _____ _____	
6. Please state if there is anything in the Assured's family history which would have increased the risk of this illness.	6. _____ _____ _____	
7. How long has the condition been medically documented?	7. _____ _____	
8. Was the Assured treated by any other doctors or hospital? If "Yes", please provide us the dates. <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
<u>Names of Physicians / Facilities</u>	<u>Addresses</u>	<u>Dates of Consultations / Confinement Periods</u>
_____	_____	_____
_____	_____	_____
9. Please give details of clinical manifestations.		
_____		
_____		
_____		

10. Diagnostics tools, including dates & results (please provide copy of reports).

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. Present Condition of the Assured.

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\_\_\_\_\_  
\_\_\_\_\_

12 Prognosis.

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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\_\_\_\_\_  
\_\_\_\_\_

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

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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. \_\_\_\_\_