



**ATTENDING PHYSICIAN'S STATEMENT**

**Female Product – Reconstructive Surgery of Breast Cancer Benefit / Breast Lumpectomy / Mastectomy**

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>	<p style="text-align: center;">Date of Onset (DD/MM/YYYY)</p> <p>Yes / No _____</p> <p>Yes / No _____</p> <p>Yes / No _____</p> <p>Yes / No _____</p> <p>Yes / No _____</p> <p>Yes / No _____</p> <p>Yes / No _____</p> <p>Yes / No _____</p> <p>Yes / No _____</p>	

7. How long has the condition been medically documented?	7. _____
8. What was the site and histology of the tumor? (Please provide copy of the histology report)	8. _____ _____
9. Is the condition malignant?	9. <input type="checkbox"/> Yes <input type="checkbox"/> No
10. Is there focal autonomous new growth of carcinomatous cells?	10. <input type="checkbox"/> Yes <input type="checkbox"/> No
11. Is there invasion of normal tissues by the carcinomatous cells? If "Yes", what is the stage of the invasion?	11. (a) <input type="checkbox"/> Yes <input type="checkbox"/> No (b) _____
12. (a) Has a mastectomy been performed as a direct result of primary breast cancer?  (b) If "No", please specify type of surgery done and date performed.	12. (a) <input type="checkbox"/> Yes Date performed _____ (DD/MM/YYYY) <input type="checkbox"/> No (b) _____ _____
13. Has reconstructive surgery of the breast been performed? If "Yes", please give details, dates and costs.	13. <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____
14. Present condition of the Assured.	14. _____ _____
15. Prognosis.	15. _____ _____
16. Was the Assured treated by any other doctors or hospitals? If "Yes", please provide us the dates, names and addresses of the doctors / hospitals.	16. <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____
17. Has the Assured suffered from/been treated for any other illnesses or complaints other than this condition? If "Yes", please provide full details.	17. <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____
18. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.	18. <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____

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. \_\_\_\_\_