



ATTENDING PHYSICIAN'S STATEMENT

Female Product– Spina Bifida

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. When were you first consulted for this illness?	2. _____ (DD/MM/YYYY)									
3. Please state if there is anything in the Assured's family history which would have increased the risk of this illness.	3. _____ _____ _____									
4. Please provide names, addresses and dates of the Assured's consultation with other physicians or medical facilities for this condition.	4. _____ _____ _____									
5. How long has the condition been medically documented?	5. _____ _____ _____									
6. When was the diagnosis made? Please state the date.	6. _____ (DD/MM/YYYY)									
7. Please give details of all investigations conducted as part of the diagnosis (including dates and results). Please attach the relevant reports, echocardiogram, X-ray etc. supporting this diagnosis.										
<table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;"><u>Date</u></td> <td style="width:50%; border: none;"><u>Results</u></td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> </table>			<u>Date</u>	<u>Results</u>	_____	_____	_____	_____	_____	_____
<u>Date</u>	<u>Results</u>									
_____	_____									
_____	_____									
_____	_____									
8. Were there clinical manifestations of meningomyelocele or meningocele?										

9. Please give details of resultant neurological deficits.										

10. Present Condition of the Assured.

11. Prognosis.

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

13. 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. _____