



ATTENDING PHYSICIAN'S STATEMENT

Female Product- Tetralogy Fallot

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. Was the Assured treated by any other doctors or hospitals? If "Yes", please provide us the dates, names and addresses of the doctors or hospitals. <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____ _____		
5. How long has the condition been medically documented? _____ _____ _____		
6. When was the diagnosis made? Please state the date. _____ (DD/MM/YYYY)		
7. Please state if there is severe or total right ventricular outflow tract obstruction. _____ _____ _____		
8. Please state if there is ventricular septal defect allowing right ventricular unoxygenated blood to bypass the pulmonary artery and enter the aorta directly. _____ _____ _____		
9. Please give dates and details of any operations performed on the Assured. Please attach the relevant reports supporting this diagnosis. _____ _____ _____		

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.