AIA PUBLIC TAKAFUL

ATTENDING PHYSICIAN'S STATEMENT

Female Product – Carcinoma-in-situ (CIS) of Cervix or Carcinoma-in-situ (CIS) of Breast

To be completed by Registered Medical Practitioner at Person Covered's / Claimant's own expense

Certificate No:	IC No:	Age:
Name of Person Covered:		Gender: ☐ Male ☐ Female

Part I - General Information

1. (a) Are you the Person Covered's usual medical physician?	1. (a) ☐ Yes ☐ No
(b) If "Yes", over what period do your records extend?	(b) _____
2. (a) When were you first consulted for this illness?	2. (a) _____ (MM/DD/YYYY)
(b) What were the symptoms/complaints?	(b) _____
(c) How long had the symptoms/complaints existed :-	
(i) According to the patient?	(c) (i) _____ Day/s _____ Week/s _____ Month/s _____ Year/s
(ii) In your medical opinion?	(ii) _____ Day/s _____ Week/s _____ Month/s _____ Year/s
3. (a) Has the Person Covered previously suffered from this illness or any related illnesses?	3. (a) ☐ Yes ☐ No
(b) If "Yes", please give dates of consultations and the resulting diagnosis.	(b) _____
(c) Was the patient referred to you?	(c) ☐ Yes ☐ No
(i) If Yes, when?	(i) _____ (MM/DD/YYYY)
(ii) Reasons for referral?	(ii) _____
(iii) Name and address of the referral doctors.	(iii) _____
4. (a) On what date was the diagnosis made?	4. (a) _____ (MM/DD/YYYY)
(b) On what date was the Person Covered first made aware of it?	(b) _____ (MM/DD/YYYY)
5. Please state if there is anything in the Person Covered's family history which would have increased the risk of this illness.	5. _____

6. Which of the following factors are present?

		Date of Onset (MM/DD/YYYY)
a) Past history of controlled hypertension	Yes / No	_____
b) Past history of uncontrolled hypertension	Yes / No	_____
c) Diabetes Mellitus	Yes / No	_____
d) Obesity	Yes / No	_____
e) Chronic smoker	Yes / No	_____
f) Heavy drinker	Yes / No	_____
g) Stress	Yes / No	_____
h) Hyperlipidaemia	Yes / No	_____

i) Others, please specify : _____

_____

7. How long has the condition been medically documented?	7. _____
8. If the diagnosis was CIS of Breast / CIS of Cervix (a) Dates and results of the latest and all previous Pap Smear tests (please provide copy of cytology reports) *Applicable to CIS of Cervix only (b) Dates & results of the biopsy or cone or colposcopy with cervical biopsy (please provide copy of stopathology reports) (c) (i) When did the Person Covered previously receive treatment for CIS of Breast / CIS of Cervix for an abnormal smear? (ii) From whom/where?	8. (a) _____ (MM/DD/YYYY) (b) _____ (MM/DD/YYYY) (c) (i) _____ (MM/DD/YYYY) (ii) _____ _____
9. Is the condition malignant?	9. ☐ Yes ☐ No
10. Is there focal autonomous new growth of carcinomatous cells?	10. ☐ Yes ☐ No
11. (a) Is there invasion of normal tissues by the carcinomatous cells? (b) If "Yes", what is the stage of the invasion?	11. (a) ☐ Yes ☐ No (b) _____
12. (a) Details with dates of medical treatment performed as well as current medication. (b) Was there any surgery performed? (c) If "Yes", please provide details of surgical procedure(s).	12. (a) _____ (MM/DD/YYYY) (b) ☐ Yes ☐ No (c) _____
13. Present condition of the Person Covered.	13. _____
14. Prognosis.	14. _____
15. Is the Person Covered HIV (Human Immunodeficiency Virus)positive?	15. ☐ Yes ☐ No
16. Was the Person Covered treated by any other doctors or hospitals? If "Yes", please provide us the dates, names and addresses of the doctors / hospitals.	16. ☐ Yes ☐ No _____ _____
17. Has the Person Covered suffered from / been treated for any other illnesses or complaints other than this condition? If "Yes", please provide full details.	17. ☐ Yes ☐ No _____ _____
18. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.	18. ☐ Yes ☐ No _____ _____

I hereby certify that I have personally examined and treated the Person Covered 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) (MM/DD/YYYY)

_____

Contact No.: _____