AIA PUBLIC TAKAFUL

ATTENDING PHYSICIAN'S STATEMENT
Critical Illness – Fulminant Viral Hepatitis
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 : _____

Part II - Details of the Person Covered's Illness

1. Please provide full and exact details of the diagnosis.	1. _____
2. Please describe the extent of the disease. (a) Approximate Date of Onset (b) Is there a rapidly decreasing liver size? (c) Is there a submassive to massive necrosis of the liver? (d) Is there a rapid degeneration of liver function? (e) Was there jaundice?	2. (a) _____ (MM/DD/YYYY) (b) ☐ Yes ☐ No (c) ☐ Yes ☐ No (d) ☐ Yes ☐ No (e) ☐ Yes ☐ No
3. What is the current condition of the Person Covered and what is the prognosis?	3. _____
4. 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.	4. ☐ Yes ☐ No _____
5. Has the Person Covered suffered from / been treated for any other illnesses or complaints other than this Critical Illness? If "Yes", please provide full details.	5. ☐ Yes ☐ No _____
6. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.	6. _____

Note: Please enclose copies of all reports including liver function test, ultrasound, MRI, X-rays and other imaging studies, laboratory evidence etc., and any relevant reports that are available.

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.: _____