AIA PUBLIC TAKAFUL

ATTENDING PHYSICIAN'S STATEMENT
Critical Illness – Loss of Independent Existence
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. Please give below, the details of any other doctors or specialists the Person Covered has consulted in connection with this illness.

Names	Addresses	Dates (MM/DD/YYYY)
(a)		
(b)		

Part II - Details of the Person Covered's Illness

1. Please provide full and exact details of the diagnosis.	1. _____
2. Investigations Done.	2. Dates (MM/DD/YYYY) Procedures Results
3. (a) Details of Treatment Rendered.	3. (a) _____
(b) Was there any surgery performed?	(b) ☐ Yes ☐ No
(c) If "Yes", please provide details of surgical procedures.	(c) _____
(d) Last Date of Consultation	(d) _____ (MM/DD/YYYY)
5. If the Person Covered is not bedridden, which of the following daily activities is the Person Covered NOT able to perform as a direct result of the trauma? Please check the appropriate item.	4. (a) ☐ Getting in an out of a chair without requiring physical assistance. ☐ The ability to move from room to room without requiring any physical assistance. ☐ The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene ☐ Putting on and taking off all necessary items of clothing without requiring assistance of another person. ☐ The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means. ☐ All tasks of getting food into the body once it has been prepared.
(b) Is such inability expected to be permanent?	(b) ☐ Yes ☐ No
5. Prognosis	5. _____
6. 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.	6. ☐ Yes ☐ No
7. 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.	7. ☐ Yes ☐ No
8. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.	8. _____

Note: Please enclose copies of all reports including biopsy, cytology reports, X-rays, CT scans, other imaging studies, laboratory evidence, surgical report, etc. and any relevant hospital 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.: _____