AIA PUBLIC TAKAFUL

## ATTENDING PHYSICIAN'S STATEMENT
### Critical Illness – Medullary Cystic Disease
**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 confirm the diagnosis of the medullary cystic disease<br><br>(a) Please give full details of any polyuria, polydipsia, growth retardation and renal failure.<br><br>(b) Please give full details of diagnostic tests performed and results e.g. renal biopsy / MRI / CT scan / Ultrasound / renal function test | 2.<br><br>(a) _____<br><br>(b) _____ |
| 3. Please provide names, dates and addresses of doctors or hospitals which the Person Covered had been referred and / or admitted to. | 3. _____ |
| 4. 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. | 4. ☐ Yes ☐ No<br>_____ |
| 5. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information. | 5. _____ |

**Note**: Please enclose copies of all reports including renal biopsy, ultrasound, blood test, renal function test and 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.: _____