AIA PUBLIC TAKAFUL

ATTENDING PHYSICIAN'S STATEMENT

Critical Illness – Parkinson's Disease or Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders

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

Note - Please tick (✓) the relevant diagnosis

☐ Parkinson's Disease ☐ Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders

Part I - General Information

1. (a) Are you the Person Covered's usual medical physician? (b) If "Yes", over what period do your records extend?	1. (a) ☐ Yes ☐ No (b) _____
2. (a) When were you first consulted for this illness? (b) What were the symptoms/complaints? (c) How long had the symptoms/complaints existed :- (i) According to the patient? (ii) In your medical opinion?	2. (a) _____ (MM/DD/YYYY) (b) _____ (c) (i) _____ Day/s _____ Week/s _____ Month/s _____ Year/s (ii) _____ Day/s _____ Week/s _____ Month/s _____ Year/s
3. (a) Has the Person Covered previously suffered from this illness or any related illnesses? (b) If "Yes", please give dates of consultations and the resulting diagnosis. (c) Was the patient referred to you? (i) If Yes, when? (ii) Reasons for referral? (iii) Name and address of the referral doctors.	3. (a) ☐ Yes ☐ No (b) _____ (c) ☐ Yes ☐ No (i) _____ (MM/DD/YYYY) (ii) _____ (iii) _____
4. (a) On what date was the diagnosis made? (b) On what date was the Person Covered first made aware of it?	4. (a) _____ (MM/DD/YYYY) (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 (i) Parkinson's Disease (a) When was the date of onset? (b) What is the diagnosis? (c) What is the cause of the disease? (ii) Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders (a) Is there evidence of deterioration or loss of Intellectual capacity or abnormal behaviour resulting in significant reduction in mental and social functioning requiring continuous supervision of the life Person Covered? If "Yes", please describe the findings. (b) Is the deterioration or loss of intellectual capacity or abnormal behaviour arise from necrosis, psychiatric, illness, any drug or alcohol related organic disorder? If "Yes", please give details.	2. (i) (a) _____ (MM/DD/YYYY) (b) _____ (c) _____ (ii) (a) ☐ Yes ☐ No _____ (b) ☐ Yes ☐ No _____
3. Is the Person Covered able to perform the following without assistance? (a) Getting in an out of a chair without requiring physical assistance. (b) The ability to move from room to room without requiring any physical assistance. (c) The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene (d) Putting on and taking off all necessary items of clothing without requiring assistance of another person. (e) 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. (f) All tasks of getting food into the body once it has been prepared.	3. _____ (a) ☐ Yes ☐ No (b) ☐ Yes ☐ No (c) ☐ Yes ☐ No (d) ☐ Yes ☐ No (e) ☐ Yes ☐ No (f) ☐ Yes ☐ No
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 _____
5. 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.	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:
(i) For Parkinson's Disease claims, please enclose copies of all neurological reports, X-rays, CT scans, and other imaging studies, laboratory evidence, cerebral angiogram and any relevant reports that is available.
(ii) For Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders claims, please enclose copies of questionnaires or test reports or 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.

_____
Signature of Attending Physician

Qualification: _____

Name & Address:
(Official Stamp) _____

Date: _____
(MM/DD/YYYY)

Contact No.: _____