AIA PUBLIC TAKAFUL

ATTENDING PHYSICIAN'S STATEMENT
Female Product– Ectopic Pregnancy / Molar Pregnancy / Eclampsia
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? (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. What were the precipitating factors?	3. _____
4. (a) Has the Person Covered a previous history of ectopic pregnancy or molar pregnancy? (b) If "Yes", please give dates of consultations and the resulting diagnosis made.	4. (a) ☐ Yes ☐ No (b) _____
5. (a) On what date was the diagnosis made? (b) On what date was the Person Covered first made aware of it?	5. (a) _____ (MM/DD/YYYY) (b) _____ (MM/DD/YYYY)
6. Please state if there is anything in the Person Covered's family history which would have increased the risk of this illness.	6. _____

7. Other physicians or medical facilities the Person Covered has consulted in connection with this illness.

Names of Physicians / Facilities	Addresses	Dates of Consultations / Confinement Periods

8. How long has the condition been medically documented?

_____

_____

_____

9. Did implantation of a fertilized ovum occur outside the uterine cavity?	9. ☐ Yes ☐ No
10. Please provide details of how the ectopic pregnancy or molar pregnancy was confirmed.	10.
11. Was the pregnancy terminated by laparotomy or laparoscopic surgery? Please give details including whether the pregnancy termination was elective or if emergency surgery was required. (Please attach copies of biopsy or any relevant reports or special investigations)	11.
12. For Eclampsia, whether her pregnancy has the following:- (a) Hypertension (b) Convulsions/seizures (c) Proteinuria (d) Oedema Please attach copies of relevant reports or special investigations.	12. (a) ☐ Yes ☐ No (b) ☐ Yes ☐ No (c) ☐ Yes ☐ No (d) ☐ Yes ☐ No
13. Present condition of the Person Covered.	13.
14. Prognosis	14.
15. Please state if the Person Covered suffered from / been treated for any other illnesses or complaints other than this condition.	15.
16. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.	16.

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.: _____