

# Attending Physician's Statement Major Disease / Critical Illness Primary Pulmonary Arterial Hypertension

Patient's Name \_\_\_\_\_

Attending Physician's Name \_\_\_\_\_

Address \_\_\_\_\_

**This section must be completed by a qualified and registered physician at the expense of the claimant.**

The above name is insured with us against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with **PRIMARY PULMONARY ARTERIAL HYPERTENSION**. To enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

## A. GENERAL INFORMATION

1. Are you the patient's usual medical doctor?  Yes  No

If yes, over what period do your records extend to?

Start date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yyyy

End date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yyyy

2. When did the patient first consult you for this condition?

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yyyy

3. Please state symptoms presented and date symptoms first appeared.

Symptoms Presented at First Consultation	Date Symptoms First Started (DD/MM/Y )

What / Who is the source of this information? \_\_\_\_\_

4. In your opinion what were the likely durations of the patient's symptoms? Please provide reasons.

\_\_\_\_\_  
 \_\_\_\_\_

5. Did the patient consult any other doctors for these symptoms before he/she consulted you?  Yes  No

If yes, please provide details below.

Name of Doctor	Name of Clinic/ Hospital and Address



If no, please state the patient's current physical and mental limitations.

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8. Has the patient previously suffered from a heart attack by any related illnesses, e.g., hypertension, angina or other vascular disease and any pulmonary disease?  Yes  No

If yes, please provide details, including diagnosis, date of diagnosis and treatment given.

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9. Have you diagnosed the following?

(a) Presence of primary pulmonary hypertension?  Yes  No

(b) Substantial right ventricular enlargement?  Yes  No

(c) Cardiac catheterization resulted in permanent physical impairment to the degree of at least Class 4 of the New York Heart Association classification of cardiac impairment?  Yes  No

- (d) Was the secondary causes of pulmonary hypertension includes but not limited to the following:

i. Chronic lung disease  Yes  No

ii. Pulmonary emboli  Yes  No

iii. Valve disease  Yes  No

iv. Left-sided heart disease  Yes  No

10. Please provide details of all investigations/tests performed and enclose copies of all reports, e.g. resting ECGs, exercise, stress tests, cardiac enzyme assays, imaging, coronary angiography, echocardiography, myocardial perfusion scans and other relevant hospital reports.

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11. Please provide the names and addresses of all clinic/hospitals to which the patient has been referred to or attended for this condition together with the names of the doctors consulted.

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**C. MEDICAL HISTORY**

12. Is there anything in the patient's medical history which would have increased the risk of Primary Pulmonary Arterial Hypertension?

If yes, please give dates of consultations, the resulting diagnosis, the name and address of attending doctor and source of information.  Yes  No

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13. Please give details of the patient's family history which would have increased the risk of a Primary Pulmonary Arterial Hypertension (including the relationship, nature of illness, date of diagnosis and source of information?).

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14. Please give details of the patient's habits in relation to past and present smoking, including the duration of smoking habits, number of cigarettes smoked per day and source of information.

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15. Please give details of the patient's habits in relation to alcohol consumption, including the amount of alcohol consumption per day and source of information.

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16. Does the patient have or ever had any other significant health condition(s)?  Yes  No

If yes, please give details of the condition, including diagnosis, date of diagnosis, duration of condition(s) and treatment received.

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**D. ADDITIONAL INFORMATION**

17. Please provide us with any other additional information that will enable the Company to assess this claim.

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**I hereby certify that the above statements are true and complete to the best of my knowledge and belief.**

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**Name of Attending Physician (Please print)**

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**Degree/Specialty**

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**Signature**

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**Date Signed**

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**PRC Number / PTR Number**

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**Telephone Number (s)**

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**To the Attending Physician :** You may use additional sheets if more space is needed for the above information requested. If you wish, please send the form directly to Claims & Settlement Department with office address shown below.