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Attending Physician's Statement
Major Disease/critical Illness
End Stage Lung Disease

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 **END STAGE LUNG DISEASE**. 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 _____ / _____ / _____ End date _____ / _____ / _____
   dd mm yyyy 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/YYYY)

   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

B. DETAILS OF MAJOR DISEASE / CRITICAL ILLNESS

6. (a) What is the diagnosis? Please provide full details of the diagnosis.

_____

_____

(b) Date of diagnosis _____ / _____ / _____
dd mm yyyy

(c) What is the underlying illness causing End Stage Lung Disease?

_____

_____

(d) Please provide the name and address of doctor and clinic/hospital where the diagnosis was first made.

Name of Doctor	Name of Clinic/Hospital	Address

(e) Date when patient was first made aware of the diagnosis? _____ / _____ / _____
dd mm yyyy

(f) Was the patient admitted in the hospital? ☐ Yes ☐ No

If yes, please state name & address of hospital _____

_____

Complaint/s _____

Date of Admission _____ Time _____ Date of Discharge _____ Time _____
Admitted Discharged

7. (a) Is the lung disease resulted from cigarette smoking or other forms of smoking? ☐ Yes ☐ No

If yes, please provide details.

_____

_____

(b) Is the lung disease resulted from drug or alcohol abuse? ☐ Yes ☐ No

If yes, please provide details.

_____

_____

8. (a) Has the patient's lung disease reached end-stage? ☐ Yes ☐ No

If yes, since when? _____ / _____ / _____
dd mm yyyy

(b) Is the lung disease causing chronic respiratory failure? ☐ Yes ☐ No

If yes, since when? _____ / _____ / _____
dd mm yyyy

(c) Is there evidence of a Forced Expiratory Volume at one second (FEV1) and test results consistently showed less than 1 liter? ☐ Yes ☐ No

If yes, please provide details.

_____

_____

(d) Will the treatment require permanent supplementary oxygen therapy for hypoxemia? ☐ Yes ☐ No

If yes, please provide details.

_____

_____

9. (a) Has lung transplantation been performed? ☐ Yes ☐ No

If yes, when was it done and by whom? (Please state name and address)

_____

_____

If no, has surgery been planned or is the patient on the waiting list for lung transplant? Please provide details.

_____

_____

(b) What is the prognosis of the patient and the treatment plan?

_____

_____

10. Please provide details of all investigations/test performed and attach copies of all hospital surgical procedures including cystoscopy report, histological, radiological reports (X-rays, etc.), laboratory reports and other relevant hospital reports.

_____

_____

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

Name of Doctor	Name of Clinic/Hospital	Address

C. MEDICAL HISTORY

12. Has the patient previously suffered from Lung Disease or any related illnesses? ☐ Yes ☐ No

If yes, please provide details including date of consultations, their resulting diagnosis, the name and address of attending doctor. Please state source of information. _____

Date of Consultation	Name and Address of Doctor	Diagnosis

13. Is there anything in the patient's medical history which would have increased the risk of Lung Disease?

☐ Yes ☐ No

If yes, please provide details including the date of consultations, their resulting diagnosis, name and address of attending doctor. Please state source of information. _____

Date of Consultation	Name / Address of Doctor	Diagnosis

14. Please give details of the patient's family history which would have increased the risk of having Lung Disease (including the relationship, nature of illness, date of diagnosis) Please state source of information. _____

_____

_____

15. 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. Please state source of information. _____

_____

_____

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

_____

_____

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

If yes, please provide details including date of consultations, their resulting diagnosis, the name and address of attending doctor. Please state source of information. _____

Date of Consultation	Name / Address of Doctor	Diagnosis

D. ADDITIONAL INFORMATION

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

_____

_____

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

Name of Attending Physician (Please print)	**Degree/Specialty**
Signature	**Date Signed**
PRC Number / PTR Number	**Telephone Number (s)**

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.