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Attending Physician's Statement
Major Disease/critical Illness
Heart Valve Replacement

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 **HEART VALVE REPLACEMENT**. 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/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 describe the full details of the diagnosis of the heart condition leading to surgery.

_____

_____

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

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

Name of Doctor	Name of Clinic/ Hospital and Address

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

(e) 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

(f) Date when patient was recommended for surgery. _____ / _____ / _____
dd mm yyyy

7. Date of onset of heart valve abnormality. _____ / _____ / _____
dd mm yyyy

8. Is the diagnosis supported by cardiac catheterization/echocardiogram? ☐ Yes ☐ No
If yes, please provide details and attach copies of reports.

_____

_____

9. (a) Has open chest surgery been performed? ☐ Yes ☐ No

If yes, please describe the surgical procedure in detail.

_____

_____

If no, please describe the surgical procedure used to correct the heart valve abnormality.

(b) Was the surgical procedure performed to repair the heart valves? ☐ Yes ☐ No

(c) Was the surgical procedure performed to replace the heart valves? ☐ Yes ☐ No

(d) Was the surgical procedure medically necessary? ☐ Yes ☐ No

(e) Date of surgery _____ / _____ / _____
dd mm yyyy

(f) Please provide the name and address of doctor and clinic/hospital who performed the surgery.

Name of Doctor	Name of Clinic/ Hospital and Address

10. Has the patient undergone similar procedure before? ☐ Yes ☐ No

If yes, please provide details including date of surgery, name and address of doctor and clinic/hospitals who performed the surgery. Please state source of information. _____

Date of Surgery	Name of Doctor / Address	Name of Clinic/Hospital / Address

11. Please provide full details of any other treatments provided.

12. Please provide details of **ALL** investigations/test performed and attach copies of results of any investigations performed. e.g. resting ECGs, exercise stress tests, cardiac enzyme assays, coronary angiography, echocardiography, surgical reports, X-rays, CT scans, myocardial perfusion scans, and any other imaging studies, laboratory evidence etc. and other relevant hospital reports.

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

Date of Consultation	Name of Physician	Name of Clinic/Hospital/Address

C. MEDICAL HISTORY

Has the patient previously suffered from Heart Valve Disease or any related illnesses? ☐ Yes ☐ No

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

Date of Consultation	Name of Doctor / Address	Diagnosis

15. Is there anything in the patient's medical history which would have increased the risk of Heart Valve Disease?
☐ Yes ☐ No

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

Date of Consultation	Name of Doctor / Address	Diagnosis

16. Please provide details of the patient's family history, which would increased the risk of Heart Valve Disease (including the relationship, nature of illness, date of diagnosis). Please state source of information. _____

_____

_____

17. Please provide 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. _____

_____

_____

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

_____

_____

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

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

Name of Doctor	Name of Clinic/ Hospital and Address	Date of Consultation/Diagnosis

D. ADDITIONAL INFORMATION

20. 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.

_____ _____

Signature Over Printed Name of Physician **Date Signed**

_____ _____

Qualification **Address**

_____ _____

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.