ATTENDING PHYSICIAN'S STATEMENT
MAJOR DISEASE/CRITICAL ILLNESS
SYSTEMIC LUPUS ERYTHEMATOSUS

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 **Systemic Lupus Erythematosus**. 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

1226 Makati City
Telephone No. 884-5433
Fax No. 884-2558

B. DETAILS OF MAJOR DISEASE / CRITICAL ILNESS

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

_____

_____

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

(c) Please provide full and exact details of the disease or condition causing Systemic Lupus Erythematosus.

_____

_____

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

Name of Doctor	Name of Clinic/ Hospital and 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) Please provide details, including dates, of the extent of the patient's Systemic Lupus Erythematosus.

_____

_____

(b) Does the illness cause multisystem and autoimmune disorder? ☐ Yes ☐ No

(c) Does the illness involve the kidneys or Central Nervous System? ☐ Yes ☐ No

(d) Do you consider the lupus nephritis severe as established by renal biopsy to be of a degree of Class III to VI as classified by WHO? ☐ Yes ☐ No

8. Has the patient experienced seizures or other permanent neurological deficits? ☐ Yes ☐ No

If yes, please provide details.

9. Can you classify the diagnosis of Systemic Lupus Erythematosus as:

a) Drug induced ☐ Yes ☐ No

b) Discoid lupus ☐ Yes ☐ No

c) Other forms, please specify _____

10. Please provide full details of current treatment provided.

11. Please provide details of all investigations/tests performed and attach copies of results of any investigations performed, e.g. resting ECGs, ultrasound, surgical reports, X-rays, MRI / CT scans, neurological reports and any other imaging studies, laboratory evidence etc., and other relevant hospital reports.

12. 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

13. Has the patient previously suffered from the condition specified above or any related illness, especially any consultations, however minor in nature, concerning neurological symptoms or complaints? ☐ Yes ☐ No

If yes, please provide details.

14. Is there anything in the patient's medical history which would have increased the risk of Systemic Lupus Erythematosus?

☐ Yes ☐ No

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

Date of Consultation	Name / Address of Doctor	Diagnosis

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

16. 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.

17. 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.

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

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

D. ADDITIONAL INFORMATION

19. 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.