

**ATTENDING PHYSICIAN'S STATEMENT
MAJOR DISEASE/CRITICAL ILLNESS
CHRONIC RELAPSING PANCREATITIS**

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 **CHRONIC RELAPSING PANCREATITIS**. 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

(c) Will the patient needs enzyme replacement therapy? Yes No

If yes, please provide details.

(d) Is the Relapsing Pancreatitis resulted from alcohol abuse? Yes No

If yes, please provide details.

8. What is the prognosis of the patient and the treatment plan?

9. Have you performed Endoscopic Retrograde Cholangio Pancreatography (ERCP)? Yes No

If yes, please provide details.

10. Please provide details of all investigations/test performed and attach copies of all hospital surgical procedures including histological, radiological reports 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 Chronic Relapsing Pancreatitis or any related illnesses? 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. _____

Date of Consultation	Name and Address of Doctor	Diagnosis

12. Is there anything in the patient's medical history which would have increased the risk of Relapsing Pancreatitis?

Yes No

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

Date of Consultation	Name / Address of Doctor	Diagnosis

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

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. Please state source of information. _____

15. 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. _____

16. 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. _____

Date of Consultation	Name / Address of Doctor	Diagnosis

D. ADDITIONAL INFORMATION

17. 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.