





(d) Is the patient currently undergoing regular peritoneal dialysis or haemodialysis?  Yes  No

If "YES", please state type of dialysis, date of first dialysis and frequency.

8. (a) Has kidney 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 kidney transplant? Please give details

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

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

10. 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.

**C. MEDICAL HISTORY**

11. Has the patient previously suffered from Renal Disease 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 and source of information.

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

Yes  No

If "YES", please provide details including the date of diagnosis, name and address of attending doctor and source of information.

13. Please give details of the patient's family history, which would have increased the risk of Renal Disease (including the relationship, nature of illness, date of diagnosis and 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 and source of this information.

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 this 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 and source of information.

**D. ADDITIONAL INFORMATION**

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

**Signature of Doctor**

**Date**

**Name and Qualification (printed)**

**Address & Official Stamp**