Manulife Financial

ATTENDING PHYSICIAN'S STATEMENT
CRITICAL ILLNESS (STROKE)

Name

NRIC Number

Policy Number

Claim Number

The abovenamed is insured with us against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with **STROKE**. To enable us to assess the claim, we would be grateful for your co-operation 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

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B. DETAILS OF CRITICAL ILLNESS

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

(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.

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

7. Please describe the initial episode.

(a) Nature of episode

(b) Date of initial episode ____ / ____ / ________
dd mm yyyy

(c) Duration of acute symptoms

(d) Is patient able to return to normal activities? ☐ Yes ☐ No

If yes, please state when: ____ / ____ / ________
dd mm yyyy

If no, please state the patient's current physical and mental limitations.

8. (a) How long has the neurological damage lasted since the initial episode? Please provide duration in hours / days / weeks.

(b) Please provide a description of the neurological damage.

(c) Is this neurological damage permanent? ☐ Yes ☐ No

(d) *Has the neurological sequela lasted more than 24 hours?* ☐ Yes ☐ No

(e) *Has there been an infarction of brain tissue, haemorrhage or embolism from an extra-cranial source? If yes, please state which of the above.* ☐ Yes ☐ No

9. Please provide details of all investigations/test performed and enclose copies of all reports, e.g. CT scan and MRI scan reports, other imaging studies, laboratory evidence, and other relevant hospital reports.

10. Are the investigation findings consistent with the diagnosis of a new Stroke? ☐ Yes ☐ No
If yes, please give details.

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.

C. MEDICAL HISTORY

12. Has the patient previously suffered from stroke or any related illnesses (e.g. hypertension, transient ischaemic attack, angina and other cardiovascular diseases)? ☐ Yes ☐ No
If yes, please provide details.

13. Is there anything in the patient's medical history which would have increased the risk of Stroke? ☐ Yes ☐ No
If yes, please give dates of consultations, the resulting diagnosis, the name and address of attending doctor and source of information.

14. Please give details of the patient's family history which would have increased the risks of having a Stroke (including the relationship, nature of illness, date of diagnosis and 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 and source of this information.

16. 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.

17. 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. OTHERS

18. Is the brain damage due to Transient Ischaemic Attack? ☐ Yes ☐ No
If yes, please provide details.

19. Is the brain damage due to an accident or injury? ☐ Yes ☐ No
If yes, please provide details.

20. Is the brain damage due to infection, vasculitis, an inflammatory disease, vascular disease affecting the eye or optic nerve? ☐ Yes ☐ No
If yes, please provide details.

21. Is the brain damage due to ischaemic disorders of the vestibular system? ☐ Yes ☐ No
If yes, please provide details.

E. ADDITIONAL INFORMATION

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

Signature of Doctor

Date

Address & Official Stamp

Name and Qualification (printed)