

## ATTENDING PHYSICIAN'S STATEMENT (HAEMOPHILIA A & HAEMOPHILIA B)

Policy No.
Claim No. <small>(For internal use)</small>

*To be completed by the Attending Physician at Insured's expense.*

### 1. PATIENT'S PARTICULARS

Name of the patient: \_\_\_\_\_ NRIC/Passport No: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Admission No: \_\_\_\_\_ Ward No: \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_

### 2. DETAILS OF PATIENT'S CONDITION

***In order for a claim under this policy to be paid, the following definition must be satisfied:***

***The insured must be suffering from severe haemophilia with a clotting factor VIII or factor IX of less than one percent (1%). Diagnosis must be confirmed by a Consultant Haematologist.***

(a) Please describe the exact details of the patient's condition.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(b) Date you were first consulted for the condition: \_\_\_\_<sub>dd</sub>\_\_\_\_ / \_\_\_\_<sub>mm</sub>\_\_\_\_ / \_\_\_\_<sub>yyyy</sub>\_\_\_\_

(c) What are the signs or symptoms presented at that time?

Signs or Symptoms presented	Date first appeared



### 3. MEDICAL HISTORY

(a) If the patient was referred from a clinic or hospital, please state:

(i) Name of referral doctor: \_\_\_\_\_

(ii) Name of clinic/ hospital: \_\_\_\_\_

(iii) Date referred: \_\_\_\_\_

(b) Did the patient consult other doctors for this illness or its symptoms before he/ she consulted you?

Yes  No

If yes, please provide the name(s) and address(es) of the doctor(s) whom he/ she consulted.

Name of Doctor	Name of Clinic/ Hospital and Address	Dates of Consultation

(c) Is the patient suffering or has suffered from any other significant illnesses?  Yes  No

If yes, please provide the following information to us.

Illness	Date of first Diagnosis	Name and Address of Attending Doctor

(d) Did you refer the patient to any other doctor(s)?  Yes  No

If yes, please provide the name and address of the doctor(s).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(e) Please give any other information which you feel would be helpful in assessment of the patient's claim.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please enclose copies of specialist or hospital reports together with any tests or similar evidence to support the validity of the patient's claim.

**Signature of Doctor**

**Date**

**Name and Qualification (printed)**

**Address & Official Stamp**