

ATTENDING PHYSICIAN'S STATEMENT (POSTPARTUM PSYCHOSIS)

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:

Postpartum Psychosis means a mental state directly caused by childbirth and is characterised by loss of insight, paranoia, nightmares, hallucinations and thoughts of harming herself or her baby. The life insured is required to be confined in a hospital or psychiatric clinic for psychiatric treatment.

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

(b) Date you were first consulted for the condition: _____ / _____ / _____

dd mm yyyy

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

<u>Signs or Symptoms presented at that time</u>	<input type="checkbox"/>	<u>Date first appeared</u>
Loss of insight	<input type="checkbox"/>	_____
Paranoia	<input type="checkbox"/>	_____
Nightmares	<input type="checkbox"/>	_____
Hallucinations	<input type="checkbox"/>	_____
Thoughts of harming herself or baby	<input type="checkbox"/>	_____
Others (please specify): _____		_____
_____		_____
_____		_____

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 she consulted you?

Yes No

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

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

(c) Was the patient previously hospitalised for this condition?

Yes No

If yes, please give details.

Name & Address of Hospital	Period (s) of Hospitalisation	
	From	To

(d) 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

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

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

Name of Doctor	Address

(f) Are you the patient's regular doctor? Yes No

If yes, since when? ____/____/____
 dd mm yyyy

If no, please provide the name and address of the patient's regular doctor.

(g) 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
