

## ATTENDING PHYSICIAN'S STATEMENT (SKIN TRANSPLANTATION DUE TO ACCIDENTAL BURNING)

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:***

***Skin transplantation due to accidental burning means the undergoing of skin transplantation for facial disfigurement due to accidental burning, or the undergoing of skin transplantation due to accidental burning affecting at least 10% of the body surface area as measured by the Lund or Browder Body Surface Chart.***

(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?

Signs or Symptoms presented	Date first appeared

(d) Date of incident resulting in major burns: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yyyy

(e) Where did the incident occur?

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(f) Please advise the circumstances leading to the burns occurring.

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(g) In your opinion, is there a possibility that the burns were self- inflicted?  Yes  No

If yes, please state your reasons.

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(h) Has the patient previously suffered from the condition specified above or any related condition? If yes, please state the dates and situations resulting in prior burns.  Yes  No

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(i) Is there anything in the patient's habits or personal history which would increase the risk of accidents or burns? If yes, please give details.  Yes  No

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(j) Please confirm the diagnosis.

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(k) Please describe the exact percentage of the body surface area affected.

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(l) Please describe the part(s) of the body affected.

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(m) Type of surgery performed: \_\_\_\_\_

(n) Was surgery required for this condition?  Yes  No

If yes, please state the reason(s) of surgery.

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

(o) Date of surgery: \_\_\_\_/\_\_\_\_/\_\_\_\_  
                                  dd                                  mm                                  yyyy

(p) Name and address of Hospital: \_\_\_\_\_

\_\_\_\_\_

(q) Name and address of the Doctor who performed the surgery.

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

(r) Please give full details of all investigations performed in relation to this condition and their results.

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

(s) Please give details of the patient's habits in relation to alcohol, cigarette smoking and drug addiction, both past and present.

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

### 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 condition 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) 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) 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**