

ATTENDING PHYSICIAN'S STATEMENT (TETRALOGY OF FALLOT)

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:

Tetralogy of Fallot means a congenital heart disease with severe or total right ventricular outflow tract obstruction, right ventricular hypertrophy and a ventricular septal defect allowing right ventricular deoxygenated blood to bypass the pulmonary artery and enter the aorta directly.

(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) What was the diagnosis?

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