Manulife

ATTENDING PHYSICIAN'S STATEMENT
PULMONARY HYPERTENSION

A) Patient's Particulars

Name of Patient	Gender

NRIC/FIN or Passport No.	Date of Birth (ddmmyyyy)

B) Patient's Medical Records

1) Please state over what period does the Hospital/Clinic's record extend?

(i) Date of first consultation (ddmmyyyy)

(ii) Date of last consultation (ddmmyyyy)

(iii) Number of consultations during the above period:

(iv) Name of hospital/clinic and Reasons for consultations (with dates):

2) Are you the patient's usual medical doctor? ❒ Yes ❒ No

If "Yes", since when? (ddmmyyyy)

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

3) Was the patient referred to you? ❒ Yes ❒ No

If "Yes", please provide:

(i) Date referred (ddmmyyyy)

(ii) Reason the patient was referred:

(iii) Name and address of doctor recommending the referral:

If "No", how did the patient come to consult at your hospital/clinic? (e.g. A&E.)

4) Have you referred the patient to any other doctor? ❒ Yes ❒ No

(i) Date referred (ddmmyyyy)

(ii) Reason for referral:

(iii) Name and address of doctor referred to:

5) Does the patient have or ever have had any significant health conditions, medical history or any illness (e.g. tumour, diabetes, hypertension, heart or asthma, etc.)? If "Yes", please provide: ❒ Yes ❒ No

Details of symptoms	Exact diagnosis	Date diagnosed	Treatment

6) Name and address of doctor whom the patient consulted for the condition(s) stated in Question 5 above.

7) What is your source of the above information?

8) 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:

No. of years of smoking	No. of sticks per day	Source of information

9) Please give details of the patient's habits in relation to **alcohol consumption**, including the amount of the alcohol consumption, frequency and the source of this information.

Type of alcohol	Quantity per Consumption	Frequency (per week / month, etc.)	Source of information

C) Details of Illness

1) Please provide details of **Pulmonary Hypertension** condition:

(i) Date the patient First consulted you for this condition (ddmmyyyy)

(ii) Details of symptom(s) presented at first consultation, and date these symptoms First started.

(iii) What is the underlying cause(s) of the symptoms?

(iv) Exact Diagnosis of the condition:

ICD-10 Code (if applicable):

(v) Date of **First** diagnosis (ddmmyyyy)

(vi) Date the patient **First** became aware of this condition (ddmmyyyy) | | | | | | | | |

2) Name and address of the doctor who first diagnosed the patient of this illness/condition.

3) Is the pulmonary hypertension due to primary or secondary causes? Please elaborate.

4) Is the disease associated with any underlying causes or conditions, or related to any congenital condition? If "Yes", please provide details: ❒ Yes ❒ No

5) Is the right ventricle of the heart enlarged? ❒ Yes ❒ No

Please attach a copy of echocardiogram report.

If "Yes", please advise date of **first** detection of the enlargement (ddmmyyyy) | | | | | | | | |

6) Was cardiac catheterisation performed to establish the diagnosis of pulmonary hypertension? ❒ Yes ❒ No

If "Yes", Please attach a copy of echocardiogram report.

7) Please provide details of **investigation** performed, with dates (e.g. Chest X-ray, echocardiogram, doppler study, CT scan, ventilation-perfusion scan, etc.)

Please **attach** a copy of the above investigations reports.

8) (i) Based on the patient's cardiac/physical impairment, please advise the class of impairment according to the New York Heart Association Classification of Cardiac Impairment?

Class _____

(ii) Please describe in detail the current symptoms.

(iii) Is such impariment likely to be permanent? ❒ Yes ❒ No

If "Yes", please explain.

9) What treatment has been administered?

10) Please provide details of **current** treatment.

11) Has transplantation been considered? ❒ Yes ❒ No

If "Yes", please provide full details.

12) Is the patient still on follow-up at your hospital / clinic? ❒ Yes ❒ No

If "Yes", please advise date of next appointment (ddmmyyyy) | | | | | | | | |

If "No", please state date of discharge (ddmmyyyy) | | | | | | | | |

D) Other Information

1) What is the prognosis of the patient's condition?

2) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for the **Pulmonary Hypertension or any possible related illness**? If "Yes", please give details: ❒ Yes ❒ No

Name of doctor and Address of hospital/clinic	Date of first & last consulation	Reasons for cosultation

3) Has the patient ever been hospitalised for the **Pulmonary Hypertension o**r its related symptoms or complications? If "Yes", please advise: ❒ Yes ❒ No

Date of hospitalisation	Reasons for hospitalisation	Treatment received (including operation, if any)	Name of doctor/surgeon & Address of hospital

4) Is there anything in the patient's **personal medical history** or **family history** which would have increased the risk of the Pulmonary Hypertension? If "Yes", please give details: ❒ Yes ❒ No

Exact diagnosis	Date of diagnosis	Name of doctor & address of hospital/clinic

5) Please describe the nature and severity of the patient's **physical** and **mental** disability and limitation, if any.

6) Please provide us with any other additioanl information that will enable the Company to assess this claim.

7) Please enclose a copy of all reports including specialist or hospital reports, echocardiogram, dopple study, laboratory evidence, surgical report, etc. that are available.

E) Declaration

I hereby declare that the above answers are true to the best of my knowledge and belief.

Signature of Doctor	Address & Offical Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	