Manulife

ATTENDING PHYSICIAN'S STATEMENT
SURGERY TO AORTA

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, hypertension, other Vascular Disease, Rheumatic Fever, diabetes, hyperlipidaemia, 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 the **conditions leading to the necessary Surgery to Aorta**:

(i) Date of First consultation for this condition (ddmmyyyy) | | | | | | | | |

(ii) Details of symptom(s) presented during the 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 the conditions requiring cardiac or abdominal Surgery to Aorta (ddmmyyyy)								

2) Please provide full details and results of all **investigation** (with dates) performed for the diagnosis and **attac**h a copy of all relevant test reports which confirmed the diagnosis.

3) Name and address of the doctor who **First** diagnosed the patient with this condition.

4) State the type of surgery performed:

5) The surgery was performed to repair or correct:

(i) Aneurysm ❒ Yes ❒ No

(ii) Narrowing or obstruction ❒ Yes ❒ No

(iii) Dissection of the Aorta ❒ Yes ❒ No

6) The surgery was performed through the surgical opening of the:

(i) Chest ❒ Yes ❒ No

(ii) Abdomen ❒ Yes ❒ No

7) The surgery was performed on the:

(i) Thoracic Aorta ❒ Yes ❒ No

(ii) Abdominal Aorta ❒ Yes ❒ No

(iii) Aortic branches ❒ Yes ❒ No

8) Was the surgery performed using:

(i) Minimally invasive technique ❒ Yes ❒ No

(ii) Intra-arterial technique ❒ Yes ❒ No

9) Date of the surgery (ddmmyyyy): | | | | | | | | |

10) What is the name of surgeon(s) who performed the surgery, and the name and address of the hospital at which surgery was performed?

11) If the surgery was performed due to aortic aneurysm or dissection, please advise:

(i) Degree of the aneurysm or dissection. Please attach a copy of the investigation reports and test results.

(ii) Site of the aneurysm or dissection:

(iii) Date of First diagnosis of thoracic or abdominal aortic aneurysm or dissection (ddmmyyyy): | | | | | | | | |

D) Other Information

1) Please describe the patient's condition when you last saw him/her, including the nature and severity of the patient's disability and limitations, if any.

2) What is the prognosis of the patient?

3) Has the patient previously suffered from any related illness leading to the Surgery to Aorta? ❒ Yes ❒ No
E.g. hypertension, angina, other vascular disease or endocarditis?

If "Yes", please provide details including diagnosed date, exact diagnosis, treatment prescribed, name and address of attending doctor.

Exact diagnosis	Date of diagnosis	Treatment	Name of doctor & Address of hospital/clinic

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

Type of Lifestyle / Exact diagnosis	Date of diagnosis	Name of doctor & Address of hospital/clinic

5) Is there anything in the patient's **family history** which would have increased the risk of this condition? If "Yes", please give details: ❒ Yes ❒ No

Relationship with patient	Nature of condition	Age of onset	Source of information

6) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for the **Surgery to Aorta** condition or any other related diseases? If "Yes", please give details: ❒ Yes ❒ No

Name of doctor and Address of hospital/clinic	Date first & last consulted	Reasons for consultation

7) Is the patient still on follow-up? If "Yes", please state: ❒ Yes ❒ No

Date of Next Appointment (ddmmyyyy) | | | | | | | | |

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

9) Please enclose a copy of all reports including specialist or hospital reports, echocardiogram report, magnetic resonance imaging report, cardiac catheterisation report, 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)	