Manulife

ATTENDING PHYSICIAN'S STATEMENT (BONE MARROW TRANSPLANT)

Policy No.
Claim No. (For internal use)

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:

The actual undergoing as a recipient of a transplant of bone marrow.

(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?

_____

_____

_____

_____

(e) Date when the condition was first diagnosed: _____/ _____/ _____
dd mm yyyy

(f) Date when the patient first became aware of the condition: _____/ _____/ _____
dd mm yyyy

(g) Date when the patient's parent first became aware of the condition: _____/ _____/ _____
dd mm yyyy

(h) Has the patient suffered any previous episodes of the underlying condition or any other condition leading to or relating to it? If yes, please give details. □ Yes □ No

_____

_____

_____

_____

(i) Are you aware of any members of the patient's close family who have suffered from this or any similar condition? If yes, please give details. □ Yes □ No

_____

_____

_____

(j) Please provide the full details of bone marrow transplant performed.

_____

_____

_____

_____

_____

(k) Please give details of the type of treatment provided including dates.

_____

_____

_____

_____

Date of transplant: _____/ _____/ _____
dd mm yyyy

(l) Name and address of Hospital: _____

_____

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

_____

_____

_____

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

_____

_____

_____

_____

_____

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

_____

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_____

_____

_____

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

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