

ATTENDING PHYSICIAN'S STATEMENT (KAWASAKI DISEASE)

Policy No.
Claim No. (For internal use)

To be completed by the Attending Physician at Insured's expense.

	PATIENT'S PARTICULA	RS			
	Name of the Patient:		NR	IC/Passport	No:
	Date of Birth:	Sex:	Admission No:	V	Vard No:
	Date of Admission:		Date of Discharge	ə:	
2.	DETAILS OF PATIENT'S	CONDITION			
	In order for a claim und	er this policv t	to be paid, the following de	efinition mu	st be satisfied:
	normal, and an elevated inflammation. A sharp retests must also reveal to	l erythrocyte s ise in the num he presence of essitates surgio	sts to detect mild anaemial sedimentation rate which in the of platelets must also f an aneurysm or any other ical treatment. Diagnosis much be patient's condition.	ndicates blo be detected or heart or b	ood vessel d. The diagnostic lood vessel
			condition:/	/	
	(c) What are the signs or				
					Date first appeared
	S	Signs or Symp	toms presented		
	S	Signs or Symp	toms presented		
	5	Signs or Symp	toms presented		
	5	Signs or Symp	toms presented		
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Reg. No. 198002116D

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(e)	Date when the condition was first diagnosed:/ /
	Date when the patient first became aware of the condition://
	Date when the patient's parent first become aware of the condition://
	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.
(i)	Are you aware of any members of the patient's close family who have suffered from this or any congenital disease? If yes, please give details.
(j)	Please confirm the diagnosis of Kawasaki Disease as described above.
(k)	Please give full details of all investigations performed in relation to this condition and their results.
	Please provide details whether there is any coronary artery aneurysm or any other heart or blood vessel abnormality and attach copies of the investigation performed confirming this.
(I)	

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	operation been p				□ Yes	□ No
(o) Please	give full details of	the op	eration performed.			
			······································			
(p) Date of	f operation:	/	/			
	any other investiga please provide de		sts or procedures bee	n performed?	□ Yes	□ No
. MEDICAL	HISTORY					
(a) If the pa	tient was referred	from a	clinic or hospital, ple	ase state:		
(i)						
('')						
(ii)	Name of clinic/ h	ospital:				
• •	Name of clinic/ h	ospital:				
(ii) (iii)	Name of clinic/ h Date referred:	ospital:				
(ii) (iii) (b) Did the	Name of clinic/ h Date referred: patient consult oth 'es □ No	nospital:	tors for this illness or	its symptoms before h	e/ she consulted	you?
(ii) (iii) (b) Did the	Name of clinic/ h Date referred: patient consult oth res	nospital:	tors for this illness or (s) and address(es) or	its symptoms before he	e/ she consulted	you?
(ii) (iii) (b) Did the	Name of clinic/ h Date referred: patient consult oth 'es □ No	nospital:	tors for this illness or (s) and address(es) or	its symptoms before h	e/ she consulted	you?
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(ii) (iii) (b) Did the	Name of clinic/ h Date referred: patient consult oth es	ner doct e name(tors for this illness or s) and address(es) or Name of Clinic/ Ho	its symptoms before he f the doctor(s) whom h pspital and Address	e/ she consulted e/ she consulted Dates of Cons	you? . sultation
(ii) (iii) (b) Did the	Name of clinic/ h Date referred: patient consult oth /es	ner doct e name(tors for this illness or s) and address(es) or Name of Clinic/ Ho ffered from any other ng information to us.	its symptoms before here the doctor(s) whom he spital and Address significant illnesses?	e/ she consulted e/ she consulted Dates of Cons	you? . sultation
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If yes, please provide the name and addre	ess of the doctor(s).
(e) Please give any other information which yo	ou feel would be helpful in assessment of the patient's cl
ease enclose copies of specialist or hospital repo	orts together with any tests or similar evidence to suppor
validity of the patient's claim.	
Signature of Doctor	Date
Signature of Doctor	Date
Signature of Doctor	Date
Signature of Doctor Name and Qualification (printed)	Date Address & Official Stamp

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