Manulife

ATTENDING PHYSICIAN'S STATEMENT (OSTEOGENESIS IMPERFECTA)

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:

This is characterised by brittle, osteoporotic, easily fractured bones. The Life Insured must be diagnosed as a Type III Osteogenesis Imperfecta confirmed by the occurrence of all of the following conditions:

(a) the result of physical examination of the Life Insured by a Medical Examiner appointed by the Company confirming that the Life Insured suffers from growth retardation, walking difficulty, hearing impairment; and

(b) the result of X-ray studies reveals diffuse and severe osteoporotic bones with multiple fractures and progressive kyphoscoliosis; and

(c) positive result of skin biopsy.

Diagnosis of Osteogenesis Imperfecta must be confirmed by a qualified paediatrician.

(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

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(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 become 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 confirm the diagnosis and the type of Osteogenesis Imperfecta.

_____

_____

_____

_____

(k) Did your patient suffered from the following:

(i) Growth retardation □ Yes □ No

(ii) Walking difficulty □ Yes □ No

(iii) Hearing Impairment □ Yes □ No

(l) Type of treatment/ medication given.

_____

_____

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

_____

_____

_____

_____

_____

(n) Has an operation been performed? □ Yes □ No

Please give full details of the operation performed.

_____

_____

_____

(o) Date of operation: _____/ _____/ _____
dd mm yyyy

(p) Have any other investigatory tests or procedures been performed? □ Yes □ No

If yes, please provide details.

_____

_____

_____

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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