Manulife

ATTENDING PHYSICIAN'S STATEMENT (RHEUMATIC FEVER WITH VALVULAR IMPAIRMENT)

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:

Rheumatic Fever with Valvular Impairment means a confirmed diagnosis by a qualified paediatrician, of acute rheumatic fever according to the Revised Jones Criteria for its diagnosis. There must be involvement of one of more heart valves with at least mild valve incompetence attributable to rheumatic fever as confirmed by quantitatives investigations of the valve function by a qualified cardiologist. The valve incompetence must persisted for at least 6 months.

(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 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 congenital disease? If yes, please give details. □ Yes □ No

_____

_____

(j) Please confirm the diagnosis of Rheumatic Fever with Valvular Impairment as described above.

_____

_____

_____

(k) Please state which of the Revised Jones Criteria the patient satisfies.

_____

_____

_____

(l) Is there any streptococcal infection? □ Yes □ No
If yes, please give details with supporting evidence.

_____

_____

(m) Details of the Heart Valve Incompetence.

(i) Is there any heart valve incompetence? □ Yes □ No
If yes, please state date of onset and cause of incompetence, as well as details of valve(s) involved.

_____

_____

_____

(ii) Please state the degree of incompetence.

_____

_____

(iii) Has it persisted for six months? □ Yes □ No

(iv) Is the heart valve incompetence attributable to rheumatic fever? □ Yes □ No

(v) Please provide details and the results of investigations performed in relation to heart valve incompetence.

_____

_____

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

If yes, 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

(q) Please give details of all investigations performed in relation to the patient's condition, and their results.

_____

_____

_____

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