Manulife

ATTENDING PHYSICIAN'S STATEMENT (SPINA BIFIDA)

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:

Spina bifida means a defective closure of the spinal column due to a neural tube defect with a resultant meningomyelocele or meningocele. Spina bifida occulta is excluded.

(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 at that time	Date first appeared

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(d) What was the diagnosis?

_____

_____

_____

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

(f) 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

_____

_____

(g) Please complete the following section relating to your patient's condition.

(i) Please confirm the diagnosis of Spina Bifida as described above.

_____

_____

_____

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

_____

_____

_____

(iii) Type of treatment/ medication given.

_____

_____

_____

(iv) Has the operation been performed? □ Yes □ No

(v) Please give full details of the operation performed.

_____

_____

_____

_____

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

(vii) Please give the name and address of the doctor who has confirmed the diagnosis of Spina Bifida.

_____

_____

_____

(h) Please complete the following section relating to the parent's condition.

(i) Was there any indication during her gestation that she may face complication or the baby may not be normal or healthy? □ Yes □ No

If yes, please furnish the type and details of tests or examinations done.

_____

_____

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

(iii) Date she was informed of her condition: _____/ _____/ _____
dd mm yyyy

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

Address & Official Stamp

Name and Qualification (printed)

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