Manulife

PART B - ATTENDING PHYSICIAN'S STATEMENT

Notes:
(1) The fee for this report is to be paid by the policyowner.
(2) Please return the completed Attending Physician's Statement with all relevant tests, Histological reports, CT Scan, etc to:

Manulife (Singapore) Pte Ltd.
8 Cross Street #15-01,
Manulife Tower,
Singapore 048424
Attention: Claims Department

Policy No.
Claim No. (For internal use)

PATIENT'S PARTICULARS

Name: _____ NRIC No/ Passport : _____

Date of Birth: _____ Occupation (if known): _____ Sex: _____

1. Has the patient consulted any other doctor(s)/ hospital(s) prior to first consultation with you? ☐ Yes ☐ No

If "Yes", please provide the name and address of the doctor(s)/ hospital(s).

_____

_____

a) Are you the patient's usual medical doctor? ☐ Yes ☐ No

If "Yes", since when? _____/ _____/ _____
dd mm yyyy

2. Date of first consultation for the current condition: _____/ _____/ _____
dd mm yyyy

a) Please state symptoms presented and date symptoms first appeared.

Symptoms Presented at First Consultation	Date symptoms first started (dd/mm/yyyy)

b) What was your diagnosis? _____

_____

c) Date of diagnosis: _____/ _____/ _____
dd mm yyyy

d) Date diagnosis was made known to the patient: _____/ _____/ _____
dd mm yyyy

3. Referral Doctor (if any)

a) If the patient was referred to you by another doctor, what was the name and address of the referral doctor? What was his/ her diagnosis?

_____

_____

_____

_____

_____

b) Date of diagnosis: _____/ _____/ _____
dd mm yyyy

c) What were his/ her advice and treatment given to the patient?

_____

_____

_____

_____

_____

4. Other source of information (if any)

a) Were you provided with information on the patient's symptoms and/ or date symptoms started by any other source?

☐ Yes ☐ No

If "Yes", please specify the name of the person and the relationship to the patient.

_____

_____

_____

5. Is the condition a result of an accident? ☐ Yes ☐ No

a) If "Yes", please describe in detail how the accident happened. If "No", please let us know if the condition is self-inflicted and provide details.

_____

_____

_____

_____

_____

b) Date of accident: _____/ _____/ _____
dd mm yyyy

c) Was the patient under the influence of alcohol? ☐ Yes ☐ No

If "Yes", what was the blood alcohol content and the reading?

_____

_____

d) Was the patient under the influence of any drugs? ☐ Yes ☐ No

If "Yes", please provide the name of drugs and results of any blood tests performed

_____

_____

_____

_____

e) Was the accident reported to the police? ☐ Yes ☐ No

If "Yes", please provide us with the name of the police station at which the accident was reported and the police report. If "No", please provide reason why not.

_____

_____

_____

_____

f) In your opinion, were the injuries sustained caused solely by the accident and not related to other causes?

☐ Yes ☐ No

If "No", what had contributed directly or indirectly to the patient's injuries?

_____

_____

_____

_____

6. Please state the periods of hospitalisation

Name of Hospital	Period(s) of Hospitalisation		Period(s) of Intensive Care	
	From	To	From	To

7. Treatment

a) Please tick if the following were done / will be done.

☐ Medical ☐ Cancer Treatment ☐ Kidney Dialysis ☐ Organ Transplant

Please provide details including date done or expected to be done and why is it necessary.

_____

_____

_____

b) **For female only:** Was the patient pregnant at time of hospitalization? ☐ Yes ☐ No

If "Yes", for how many months? _____

c) Is the current treatment associated with the following: -

(i) Pregnancy, childbirth or miscarriage or complications from pregnancy or childbirth	☐ Yes	☐ No
(ii) Prenatal or postnatal care	☐ Yes	☐ No
(iii) Birth control/ Sterilisation	☐ Yes	☐ No
(iv) Infertility/ Subfertility	☐ Yes	☐ No
(v) Abortion	☐ Yes	☐ No
(vi) Routine health check-up	☐ Yes	☐ No
(vii) Dental care or surgery	☐ Yes	☐ No
(viii) Alcoholism	☐ Yes	☐ No
(ix) Drug addiction or abuse	☐ Yes	☐ No
(x) Mental or nervous disorder or "rest cures"	☐ Yes	☐ No
(xi) Birth defects	☐ Yes	☐ No
(xii) Hereditary conditions	☐ Yes	☐ No
(xiii) Congenital sickness or abnormalities	☐ Yes	☐ No
(xiv) Obesity, weight reduction or weight improvement	☐ Yes	☐ No
(xv) Sexually-transmitted disease, AIDS or any illness caused by or related to the Human Immuno-deficiency Virus (HIV)	☐ Yes	☐ No

If you have ticked "Yes" to any of the above boxes, please provide details.

_____

_____

_____

d) Is the patient still on follow-up treatment? ☐ Yes ☐ No

If "yes", please specify the type of treatment/ medication.

_____

_____

_____

e) How frequent does the patient seeks treatment since discharge from hospital?

_____

_____

_____

f) What is the expected length of follow-up?

_____

_____

_____

8. Surgery

a) Was surgery performed for this condition? ☐ Yes ☐ No

If "Yes", please specify.

Nature of Surgical Operation(s)	Date(s) performed (dd/mm/yyyy)

b) Is the surgery performed an elective or plastic surgery? ☐ Yes ☐ No

If "Yes", please provide details.

_____

_____

_____

c) Is further surgery likely to be required? ☐ Yes ☐ No

If "Yes", please state tentative date of surgery: _____/ _____/ _____
dd mm yyyy

9. Medical History

a) Has the patient previously suffered from the same illness in respect of which he/ she is claiming now?

☐ Yes ☐ No

If "Yes", please state:

(i) Date when illness was first diagnosed: _____/ _____/ _____
dd mm yyyy

(ii) Name and address of the doctor who first treated him/ her

_____

_____

b) Has the patient been admitted to any hospital before, either for the same or different cause? If "yes", please provide details below. ☐ Yes ☐ No

Period(s) of Hospitalisation	Diagnosis	Hospital	Name(s) and Address(es) of Attending Doctor

c) Is the patient suffering or has suffered from any other significant illnesses? ☐ Yes ☐ No

Description of Illness(es)	Date(s) of Consultations (dd/mm/yyyy)	Name(s) and Address(es) of Attending Doctor

10. Please provide us any other additional information that will enable the Company to assess this claim.

_____

_____

_____

_____

11. 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