

**ATTENDING PHYSICIAN'S STATEMENT
(DISSEMINATED AND INTRAVASCULAR
COAGULATION)**

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:

Disseminated Intravascular Coagulation means generation of fibrin in the blood stream caused by entrance of material with tissue factor activity which initiates bleeding clotting. The over-consumption of blood clotting factors causes major haemorrhage. Disseminated Intravascular Coagulation due to abortion or arising during the first seven months of pregnancy 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 symptoms did the patient complain of when she first saw you for this condition?

(d) According to the patient, how long has she been experiencing these symptoms?

(e) For how long do you think the patient has actually experienced these symptoms?

(f) What was the diagnosis?

(g) Date when the condition was first diagnosed: ____ / ____ / ____
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.

(i) Please confirm the diagnosis of Disseminated Intravascular Coagulation as described above.

(j) Please state the duration of pregnancy: _____

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

(l) Please state the cause of Disseminated Intravascular Coagulation.

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

(n) Date of operation: ____ / ____ / ____
dd mm yyyy

(o) Please advise the name and address of the doctor who has confirmed the diagnosis of Disseminated Intravascular Coagulation.

(p) Please give details of the patient's habits in relation to alcohol, cigarette smoking and drug addiction, both past and present.

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 she consulted you?

Yes No

If yes, please provide the name(s) and address(es) of the doctor(s) whom 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

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Tel: 67371221 Website: www.manulife.com.sg

(d) Are you the patient's regular doctor?

Yes No

If yes, since when? _____ / _____ / _____
dd mm yyyy

If no, please provide the name and address of the patient's regular doctor.

(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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