
**ATTENDING PHYSICIAN'S STATEMENT
(ECTOPIC PREGNANCY)**

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:******Ectopic Pregnancy means pregnancy in which implantation of a fertilised ovum occurs outside the uterine cavity.***

(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?

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