

ATTENDING PHYSICIAN'S STATEMENT (HYDROCEPHALUS)

Policy No.
Claim No. <small>(For internal use)</small>

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:

Hydrocephalus means an excessive accumulation of cerebrospinal fluid within the cerebral ventricles. Benefit is payable only if the condition is serious enough to warrant the placement of a shunt.

(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

(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 Hydrocephalus as described above.

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

(iii) Has the operation been performed? Yes No

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

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

(vi) Please provide full details of neurological deficit.

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

Manulife (Singapore) Pte Ltd.

Reg. No. 198002116D

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(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

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