

ATTENDING PHYSICIAN'S STATEMENT (RHEUMATIC FEVER WITH VALVULAR IMPAIRMENT)

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:

Rheumatic Fever with Valvular Impairment means a confirmed diagnosis by a qualified paediatrician, of acute rheumatic fever according to the Revised Jones Criteria for its diagnosis. There must be involvement of one of more heart valves with at least mild valve incompetence attributable to rheumatic fever as confirmed by quantitative investigations of the valve function by a qualified cardiologist. The valve incompetence must persisted for at least 6 months.

(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	Date first appeared

(ii) Please state the degree of incompetence.

(iii) Has it persisted for six months? Yes No

(iv) Is the heart valve incompetence attributable to rheumatic fever? Yes No

(v) Please provide details and the results of investigations performed in relation to heart valve incompetence.

(n) Has an operation been performed? Yes No

If yes, please give full details of the operation performed.

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

(p) Have any other investigatory tests or procedures been performed? Yes No

(q) Please give details of all investigations performed in relation to the patient's condition, and their results.

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

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Reg. No. 198002116D

Main Office: 8 Cross Street #15-01, Manulife Tower, Singapore 048424

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

(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

Name and Qualification (printed)

Address & Official Stamp

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