

**ATTENDING PHYSICIAN'S STATEMENT
MAJOR DISEASE / CRITICAL ILLNESS
CORONARY ARTERY BY- PASS SURGERY**

Patient's Name

Attending Physician's Name

Address

This section must be completed by a qualified and registered physician at the expense of the claimant.

The above name is insured with us against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with **CORONARY ARTERY BY-PASS SURGERY**. To enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

A. GENERAL INFORMATION

1. Are you the patient's usual medical doctor? Yes No

If yes, over what period do your records extend to?

Start date ___ / ___ / ___
 dd mm yyyy

End date ___ / ___ / ___
 dd mm yyyy

2. When did the patient first consult you for this condition? ___ / ___ / ___
 dd mm yyyy

3. Please state symptoms presented and date symptoms first appeared.

Symptoms Presented at First Consultation	Date Symptoms First Started (DD/MM/Y)

What / Who is the source of this information? _____

4. In your opinion what were the likely durations of the patient's symptoms? Please provide reasons.

5. Did the patient consult any other doctors for these symptoms before he/she consulted you? Yes No
If yes, please provide details below.

Name of Doctor	Name of Clinic/ Hospital and Address

10. (a) Has an open chest surgery been performed? Yes No

If yes, please describe the surgical procedure in detail.

(b) Date of surgery _____ / _____ / _____
 dd mm yyyy

(c) Name and address of the doctor who performed the surgery.

(d) Name and address of the hospital where the surgery was performed.

11. If coronary by-pass grafting has been performed, please state the number and sites of graft inserted.

12. Please provide full details of any other treatment provided.

13. Please provide the names and addresses of all clinics/hospitals to which the patient has been referred to or attended for this condition together with the names of the doctors consulted.

Date of Consultation	Name of Physician	Name of Clinic/Hospital/Address

C. MEDICAL HISTORY

14. Has the patient previously suffered from any related illness of hypertension, angina or any other cardiovascular diseases?

Yes No

If yes, please provide dates of consultations, the resulting diagnosis, the name and address of attending doctor. Please state source of information. _____

Date of Consultation	Name of Doctor / Address	Diagnosis

15. Is there anything in the patient's medical history which would have increased the risk of Coronary Artery Disease?

Yes No

If yes, please provide full details including the date of diagnosis, name and address of attending doctor. Please state source of information. _____

Date of Consultation	Name of Doctor / Address	Diagnosis

16. Please provide details of the patient's family history, which would increased the risk of Coronary artery Disease (including the relationship, nature of illness, date of diagnosis). Please state source of information. _____

17. Please provide details of the patient's habits in relation to past and present smoking, including the duration of smoking habits, number of cigarettes smoked per day. Please state source of information. _____

18. Please provide details of the patient's habits in relation to alcohol consumption, including the amount of alcohol consumption per day. Please state source of information. _____

19. Does the patient have or ever had any other significant health condition(s)? Yes No

If yes, please provide details including dates of consultations, their resulting diagnosis, the name and address of attending doctor. Please state source of information. _____

Name of Doctor	Name of Clinic/ Hospital and Address	Date of Consultation/Diagnosis

D. ADDITIONAL INFORMATION

20. Was the coronary artery condition treated only by angioplasty and all other intra arterial, catheter based techniques, "keyhole" or laser procedures? Yes No

If yes, please describe the treatment administered.

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

I hereby certify that the above statements are true and complete to the best of my knowledge and belief.

Signature Over Printed Name of Physician

Date Signed

Qualification

Address

PRC Number / PTR Number

Telephone Number (s)

To the Attending Physician : You may use additional sheets if more space is needed for the above information requested. If you wish, please send the form directly to Claims & Settlement Department with office address shown below.