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ATTENDING PHYSICIAN'S STATEMENT MAJOR DISEASE/CRITICAL ILLNESS COMA

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 **COMA**. 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 _____ / _____ / _____ End date _____ / _____ / _____
   dd mm yyyy 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/YYYY)

   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

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B. DETAILS OF MAJOR DISEASE / CRITICAL ILNESS

6. (a) What is the diagnosis? Please provide full details of the diagnosis. _____

_____

_____

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

(c) Please provide any other details of the injury, disease or condition causing coma, including the date of and time of onset.

_____

_____

(d) Please provide the name and address of doctor and clinic/hospital where the diagnosis was first made.

Name of Doctor	Name of Clinic/ Hospital and Address

(e) Date when patient was first made aware of the diagnosis? _____ / _____ / _____
dd mm yyyy

(f) Was the patient admitted in the hospital? ☐ Yes ☐ No

If yes, please state name & address of hospital _____

_____

Complaint/s _____

Date of Admission _____ Time _____ Date of Discharge _____ Time _____
Admitted Discharged

7. Please describe the extent of the Coma.

(a) Date of onset _____ / _____ / _____
dd mm yyyy

(b) How many hours was patient in a state of coma, with no response to external stimuli or internal needs?

_____

_____

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(c) Was there no response to external stimuli for at least 96 hours? ☐ Yes ☐ No

(d) Does the patient require life support measures to sustain life? ☐ Yes ☐ No

If yes, please give details of the life support measures.

(e) Was there any brain damage resulting in a permanent neurological deficit 30 days after the onset of the Coma?

☐ Yes ☐ No

If yes, please give details of the life support measures.

8. Please provide full details of tests and results which have been performed to establish the diagnosis of Coma, and attach copies of all relevant hospital reports, laboratory and test results, including neurological reports, CT scans, MRI and other imaging studies and surgical reports.

9. Please provide details of treatment administered.

10. Please provide the date and time of emergence from the state of no response to external stimuli.

Date ☐ Time ☐

11. What is the current condition of the patient?

12. What is the prognosis?

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13. Was the Coma resulting directly from alcohol or drug abuse? ☐ Yes ☐ No

If yes, please provide full details.

_____

_____

14. Was the Coma a result of a self-inflicted act? ☐ Yes ☐ No

If yes, please provide full details.

_____

_____

15. 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 doctors consulted.

Name of Doctor	Name of Clinic/ Hospital and Address

C. MEDICAL HISTORY

16. Has the patient previously suffered from any related illnesses / condition that caused the Coma? ☐ 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._____

Date of Consultation	Name of Doctor / Address	Diagnosis

17. Is there anything in the patient's medical history which would have increased the risk of Coma?

☐ Yes ☐ No

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

Date of Consultation	Name of Doctor / Address	Diagnosis

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18. Please give details of the patient's family history which would have increased the risk of Coma (including the relationship, nature of illness, date of diagnosis) Please state source of information. _____

19. Please give 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 and source of information.

20. Please give details of the patient's habits in relation to alcohol consumption, including the amount of alcohol consumption per day and source of information.

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

    If yes, please provide details of the condition, including diagnosis, date of diagnosis, duration of condition(s) and treatment received.

D. ADDITIONAL INFORMATION

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

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

Name of Attending Physician (Please print)	**Degree/Specialty**
Signature	**Date Signed**
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.