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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

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B. DETAILS OF MAJOR DISEASE / CRITICAL ILLNESS

6. (a) What is the diagnosis? Please describe the full details of the diagnosis of the heart condition leading to surgery.

_____

_____

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

(c) 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

(d) 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 provide details of the coronary angiogram performed.

_____

_____

8. Which arteries were involved and what was the degree (%) of narrowing in respect of each artery involved?

_____

_____

9. Was coronary anteriography performed? ☐ Yes ☐ No

_____

_____

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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

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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.