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ATTENDING PHYSICIAN'S STATEMENT MAJOR DISEASE/CRITICAL ILLNESS KIDNEY FAILURE

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 **KIDNEY FAILURE**. 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) What is the underlying renal disease causing Kidney Failure?

_____

_____

(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	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. (a) Is there chronic renal failure of both kidneys? ☐ Yes ☐ No

If yes, since when? _____ / _____ / _____
dd mm yyyy

(b) Is the kidney failure reversible? ☐ Yes ☐ No

Has the patient's kidney failure reached end-stage? ☐ Yes ☐ No

If yes, since when? _____ / _____ / _____
dd mm yyyy

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(c) Is the patient currently undergoing permanent renal dialysis? ☐ Yes ☐ No

If yes, please state type of dialysis, date of first dialysis and frequency.

(d) Is the patient currently undergoing regular peritoneal dialysis or hemodialysis? ☐ Yes ☐ No
If yes, please state type of dialysis, date of first dialysis and frequency

8. (a) Has kidney transplantation been performed? ☐ Yes ☐ No
If yes, when was it done and by whom? (Please state name and address)

If no, has surgery been planned or is the patient on the waiting list for kidney transplant? Please provide details.

(b) What is the prognosis of the patient and the treatment plan?

9. Please provide details of all investigations/test performed and attach copies of all hospital surgical procedures including cystoscopy report, histological, radiological reports (X-rays, pyelogram etc.), laboratory reports and other relevant hospital reports.

10. 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.

Name of Doctor	Name of Clinic/Hospital	Address

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C. MEDICAL HISTORY

11. Has the patient previously suffered from Renal Disease or any related illnesses? ☐ 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 and Address of Doctor	Diagnosis

12. Is there anything in the patient's medical history which would have increased the risk of Renal Disease? ☐ Yes ☐ No

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

Date of Consultation	Name / Address of Doctor	Diagnosis

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

_____

_____

14. 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. Please state source of information. _____

_____

_____

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

_____

_____

_____

_____

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16. 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. _____

Date of Consultation	Name / Address of Doctor	Diagnosis

D. ADDITIONAL INFORMATION

17. 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.