

# ATTENDING PHYSICIAN'S STATEMENT MAJOR DISEASE/CRITICAL ILLNESS PARALYSIS

Pat	ient's Name					
Attending Physician's Name		Address				
Thi	s section must be completed by a qualified and regi	stered physician at the expense of the claimant.				
bee		of certain contingent events associated with his/her health. A claim has us to assess the claim, we would be grateful for your cooperation in the				
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///// yyyy				
2.	When did the patient first consult you for this condition					
3.	Please state symptoms presented and date symptoms first appeared.					
	Symptoms Presented at First Consultation	Date Symptoms First Started (DD/MM/YYYY)				
4.	In your opinion what were the likely durations of the pa	itient'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				
		1				

# **|||** Manulife

### B. DETAILS OF MAJOR DISEASE / CRITICAL ILNESS

(b)	Date of diagnosis	/	уууу			
(c)	(c) Please provide the name and address of doctor and clinic/hospital where the diagnosis was first made.					
Name of Doctor		Nam	Name of Clinic/ Hospital and Address			
(d)	Date when patient was first mad	e aware of the diagnosis?	/	/		
(e)	Was the patient admitted in the	nospital? Yes	□ No	уууу		
	If yes, please state name & address of hospital					
		TimeDate o		Time		
		Admitted Discharged Please describe the extent of the Paralysis.				
Ple	ase describe the extent of the Par	alysis////	ууу			
Ple	ase describe the extent of the Par	alysis////				
Plea (a)	ase describe the extent of the Par  Date of onset	alysis////				
Plea (a)	ase describe the extent of the Par  Date of onset  Number of limbs involved :  Which limbs are involved :	alysis. //	ууу	total (100%, that is, co		

# **|||** Manulife

(e) What is the grading muscle strength?						
(f)	Is there total and irreversible loss of use of the in If yes, please provide basis for prognosis.	nvolved limbs?	Yes	□ No		
(g)	Is the total and irreversible severance above the	wrist or ankle?	Yes	☐ No		
(h)	Did the paralysis result from a self-inflicted act?  If yes, please give full details.		☐ Yes	□ No		
Plea	ase provide details of current treatment provided.					
Wha	at is the prognosis?					
copi	ase provide full details of tests and results which ies of all relevant hospital reports, laboratory ar ging studies and surgical reports.					
copi imag	ies of all relevant hospital reports, laboratory ar	nd test results, included the control of the contro	ding neurologic	al reports, CT scans, MRI and		
copi imag	ies of all relevant hospital reports, laboratory arging studies and surgical reports.  ase provide the names and addresses of all clinic	cs/hospitals to which	the patient has	al reports, CT scans, MRI and		

# **|||** Manulife

C.	C. MEDICAL HISTORY				
12.	Has the patient previously suffered from the condition specified above or any related illnesses?				
	If yes, please provide details including date of consultations, their resulting diagnosis, the name and address of attending. Please state source of information.				
	Date of Consultation	Name of Doctor / Address	Diagnosis		
13.	Is there anything in the patient's medic	cal history which would have increased the risk of	f Paralysis?		
	Yes No  If yes, please provide details including the date of consultations and their resulting diagnosis, name and address of attending doctor. Please state source of information.				
	Date of Consultation	Name of Doctor / Address	Diagnosis		
14.	<ol> <li>Please give details of the patient's family history which would have increased the risk of Paralysis (including the relations nature of illness, date of diagnosis) Please state source of information.</li> </ol>				
15.	5. 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.				
16.	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.				



17.	Does the patient have or ever had any other significant health cond	lition(s)?	Yes	☐ No	
	If yes, please provide details of the condition, including diagnosis received.	, date of o	liagnosis, duration	of condition(s) and treatment	
D.	ADDITIONAL INFORMATION				
18. Please provide us with any other additional information that will enable the Company to assess				his claim.	
l he	reby certify that the above statements are true and compl	ete to the	e best of my kno	owledge and belief.	
	Name of Attending Physician (Please print)		Degree/Specialty  Date Signed		
Signature					
	PRC Number / PTR Number	_	Telephon	e Number (s)	
	the Attending Physician : You may use additional sheets uested. If you wish, please send the form directly to Claims ow.				