



**Critical Illness Claim - Doctor's Statement  
Angioplasty and Other Invasive Treatment for Coronary Artery**

**SECTION 2 – DOCTOR'S STATEMENT** (to be completed by the attending doctor at claimant's expense)

<b>A) Patient's Particulars</b>									
Name of Patient	Gender								
NRIC/FIN or Passport No.	Date of Birth (ddmmyyyy) <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>								

<b>B) Patient's Medical Records</b>									
<p>1) Please state over what period does the Hospital/Clinic's record extend?</p> <p>(i) Date of First Consultation (ddmmyyyy)</p> <p>(ii) Date of Last Consultation (ddmmyyyy)</p> <p>(iii) Number of consultations during the above period:</p> <p>(iv) Name of hospital/clinic and Reasons for consultations (with dates):</p>	<table border="1" style="width:100%; height: 40px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>								
<p>2) Are you the patient's usual medical doctor? <span style="float:right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>If "Yes", since when? (ddmmyyyy)</p> <p>If "No", please provide name and address of the patient's regular doctor.</p>	<table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>								
<p>3) Was the patient referred to you? <span style="float:right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p><b>If "Yes"</b>, please provide:</p> <p>(i) Date referred (ddmmyyyy)</p> <p>(ii) Reason the patient was referred:</p> <p>(iii) Name and address of doctor recommending the referral:</p> <p><b>If "No"</b>, how did the patient come to consult at your hospital/clinic? (e.g. A&amp;E.)</p>	<table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>								
<p>4) Have you referred the patient to any other doctor? <span style="float:right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>(i) Date referred (ddmmyyyy)</p> <p>(ii) Reason for referral:</p> <p>(iii) Name and address of doctor referred to:</p>	<table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>								

5) Does the patient have or ever have had any significant health conditions, medical history or any illness (e.g. tumour, hepatitis, hyperlipidaemia, hypertension, diabetes, etc.)?  Yes  No

If "Yes", please provide:

<u>Details of symptoms</u>	<u>Exact diagnosis</u>	<u>Date diagnosed</u>	<u>Treatment</u>

6) Name and address of doctor whom the patient consulted for the condition(s) stated in Question 5 above.

7) What is your source of the above information?

8) 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 this information:

<u>No. of years of smoking</u>	<u>No. of sticks per day</u>	<u>Source of information</u>

9) Please give details of the patient's habits in relation to **alcohol consumption**, including the amount of the alcohol consumption, frequency and the source of this information.

<u>Type of alcohol</u>	<u>Quantity per Consumption</u>	<u>Frequency (per week / month, etc)</u>	<u>Source of information</u>

**C) Details of Illness**

1) Please provide details of the heart disease that led to **Coronary Angioplasty or similar intra-arterial catheter procedure**:

(i) Date of First consultation for this condition (ddmmyyyy) 

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(ii) Details of symptom(s) presented during the First consultation, and date these symptoms First started.

(iii) What is the underlying cause(s) of the symptoms?

(iv) Exact Diagnosis of the condition:

ICD-10 Code (if applicable):

(v) Date of First diagnosis (ddmmyyyy)

(vi) Date the patient first became aware of the illness/condition (ddmmyyyy)

2) Name and address of the cardiologist who **First** diagnosed the patient with this condition.

3) Please state type of procedure performed.

4) Date the procedure was performed (ddmmyyyy)

5) Please specify the coronary arteries involved and the degree (%) of narrowing, and **attach** a copy of **Angiogram report**.

Coronary Artery	Stenosis	Percentage of Stenosis
Left Main Stem	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Left Anterior Descending Artery	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Left Circumflex Artery	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Right Coronary Artery	<input type="checkbox"/> Yes <input type="checkbox"/> No	

6) Name of surgeon who performed the procedure and name of hospital in which it was performed.

7) Please provide full details of any other treatment provided.

8) Was the procedure considered medically necessary by the consultant cardiologist?  Yes  No

9) Has the patient undergone a similar procedure before?  Yes  No  
 If "Yes", please state date and place where it was performed, and the reason(s) for the procedure.

10) Did the patient previously suffer from coronary artery disease or any related illness?  Yes  No  
 If "Yes", please provide details including date of diagnosis, exact diagnosis, treatment prescribed, and name and address of attending doctor.

11) Have any other investigative tests or procedure been performed?  Yes  No  
 If "Yes", please provide details and attach a copy of results (e.g. angioplasty operation report, myocardial perfusion test, 2-D echocardiogram, etc).

**D) Other Information**

1) Is there anything in the patient's **personal medical history** which would have increased the risk of Coronary Artery Disease? If "Yes", please give details:  Yes  No

<u>Exact diagnosis</u>	<u>Date of diagnosis</u>	<u>Name of doctor &amp; Address of hospital/clinic</u>
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2) Is there anything in the patient's **family history** which would have increased the risk of Coronary Artery Disease? If "Yes", please give details:  Yes  No

<u>Relationship with patient</u>	<u>Nature of condition</u>	<u>Age of onset</u>	<u>Source of information</u>
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3) Please describe and elaborate on the nature and severity of the patient's disability and limitation, if any.

4) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient has also consulted for **Coronary Artery Disease** or any other related diseases?  Yes  No

If "Yes", please give details:

Name of doctor and Address of hospital/clinic

Date first & last consulted

Reasons for consultation

5) Is the patient still on follow-up?  Yes  No

If "Yes", please state date of next appointment (ddmmyyyy)

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If "No", please state date of discharge (ddmmyyyy)

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

7) Please enclose copies of all reports including specialist or hospital reports (e.g. Exercise stress tests, cardiac enzyme assays, coronary angiography, echocardiography, surgical reports, X-rays, CT scans, myocardial perfusion scans, and any other imaging studies, laboratory evidence, etc) and any relevant hospital reports that are available.

**E) Declaration**

I hereby declare that the above answers are true to the best of my knowledge and belief.

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Signature of Doctor

Address & Official Stamp of Doctor

Name of Doctor

Date (ddmmyyyy)