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CRITICAL ILLNESS CLAIM FORM

ATTENDING PHYSICIAN'S STATEMENT

Agency/Agent's Code ____________________

Policy No. ____________________ Service No. ____________________ (Office use only)

1 This printed form is issued on receipt of notice of illness, and is no way an admission of liability.
2 This form is to be completed by the Attending Doctor at claimant's expenses.
3 For Critical Illness claim, the original or certified true copy of the investigation or histology reports must be attached to substantiate the claim.

DEFINITION

CHRONIC LUNG DISEASE

End stage respiratory failure including chronic interstitial lung disease
The following criteria must be met:

a) Requiring permanent oxygen therapy as a result of consistent FEV 1 test value of less than one liter. (Forced Expiratory Volume during the first second of a forced exhalation)
b) Arterial Blood Gas analysis with partial oxygen pressures of 55mmHg or less
c) Dyspnoea at rest

PERSONAL PARTICULAR

1 Name : ____________________ I.C. No : ____________________

2 Occupation: ____________________ Age/Sex : ____________________

3 Please give details of your patient's smoking habits, both past and present.

____

4 Are you aware of any members of the patient's close family who have suffered from this or any similar condition ? If yes, please give details.

____

5 Has the patient ever been exposed to any other substance that is likely to increase the risk of lung disease? If yes, kindly furnish the details

____

____

ILLNESS

6 Date you first saw the patient for this condition. [| | | | |] (DD/MM/YY)

7 Was the patient referred to your clinic by any other doctor ? If yes, please indicate name and address of the referral doctor.

____

8 What were the symptoms the patient complaint of when he/she first saw you ?

____

9 According to the patient, how long had he/she been experiencing these symptom prior to consulting you and what were the frequency and severity of the symptoms.

____

10 In your professional opinion, how long would it take for the patient condition to develop ? Kindly advise reason if answer in Q(8) and Q(9) is different.

____

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11 What was your diagnosis ? Kindly advise date of diagnosis.

i Diagnosis : ______________ Date : [| | | | |] (DD/MM/YY)

ii Please describe full details of your patient condition.

____

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12 Please provide us the following:-

i Are the FEV1 test results consistently less than 1 litre? ☐ Yes ☐ No

If NO, please give the actual readings [ ]

ii Is there permanent oxygen therapy? ☐ Yes ☐ No

iii Is there Arterial Blood Gas analysis with partial oxygen pressures of 55mmHg or less (PaO_2 55mmHg)? ☐ Yes ☐ No

If NO, please give the actual readings [ ]

iv Is there Dyspnoea at rest? [ ]

13 Please furnish us full details (including dates) of investigation together with the results i.e. lung function tests, PEFR, FEV, bronchograms etc. Please **enclosed a copy of the result.**

Dates	Type of test	Results

14 Please state current treatment being administered and medication including planned surgery.

____

15 If oxygen therapy is neccesitated, please advise on how frequently and where this is administered.

____

16 Have the patient previously received treatment for the above condition ? ☐ Yes ☐ No

If yes, please give details of treatment inclusive of date, name and address of the doctor.

Date	Doctor's name and address	Treatment

17 Please give any other information which you feel would be helpful in the assessment of your patient's claim

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GENERAL INFORMATION

18 Are you the patient's Usual Medical Attendant? If so, since when? ______________

19 If no, please give name and address of his/her Usual Medical Attendant if known to you.

____

20 Please state from your records the details of all illnesses, accidents, surgical operations or disease from which the deceased had suffered or had been treated at your clinic. (Please use additional sheet, if necessary.

Date of Consultation	Diagnosis	Treatment

I hereby certify that I have examined the above patient and that the injury/sickness stated above represent my medical opinion of the patient's condition.

Name of Doctor : ______________

Qualification : ______________

____

Signature

Date :

____

Hospital/Clinic Stamp