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CRITICAL ILLNESS CLAIM FORM
ATTENDING PHYSICIAN'S STATEMENT

Agency/Agent's Code : _____
Policy No. : _____

1 This printed form is issued on receipt of notice of illness, and is not 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

Stroke is defined as :

Cerebrovascular accident or incident producing neurological sequelae of a permanent nature, having lasted not less than six months. Infarction of brain tissue, haemorrhage and embolization from an extracranial source are included.

The diagnosis must be based on changes seen in a CT scan or MRI and certified by a neurologist.

Specifically excluded are cerebral symptoms due to transient ischaemic attacks, any reversible ischaemic neurological deficit, vertebrobasilar ischaemia, cerebral symptoms due to migraine, cerebral injury resulting from trauma or hypoxia and vascular disease affecting the eye or optic nerve or vestibular functions.

PERSONAL PARTICULARS

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.

_____

ILLNESS

5 Date you first saw the patient for this condition. ☐☐☐☐☐☐ (DD/MM/YY)

6 What were the symptoms the patient complained of when he/she first saw you ?

_____

7 According to the patient, how long had he/she been experiencing these symptoms prior to consulting you?

_____

8 In your professional opinion, how long would it take for the patient's condition to develop ? Kindly advise reason if answer in Q(7) and Q(8) is different.

_____

9 Please confirm the diagnosis of stroke.

_____

10 Kindly advise us the date of dignosis. ☐☐☐☐☐☐ (DD/MM/YY)

11 Is the disease congenital or hereditary ?

_____

12 What is the constributor/cause of stroke ?

_____

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13 Please give details of any residual deficit and advise whether this is likely to prove to be permanent.

14 Was CT Scan or MRI taken? If yes, please furnish certified true copy of reports or details — Yes ☐ No ☐

15 Has your patient suffered any previous episodes of this condition or any other conditions leading to it or relating to it? If so please give details.

16 Does your patient sustained any one of the below ?

	Yes	No
i) cerebral symptoms due to transient ischaemic attacks	☐	☐
ii) any reversible ischaemic neurological deficit	☐	☐
iii) vertebrobasilar ischaemic	☐	☐
iv) cerebral symptoms due to migraine	☐	☐
v) cerebral injury resulting from trauma or hypoxia	☐	☐
vi) vascular disease affecting the eye or optic nerve or vestibular functions.	☐	☐

17 Would you classify your patient's condition as our stroke definition ? Please give details.

18 Have the patient previously received treatment for the above condition ? ☐ Yes ☐ No
If yes, please give details of treatment inclusive of date.

GENERAL INFORMATION

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

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

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

22 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	Disease/Injury

23 Please give names and addresses of all other Physician or Medical Practitioner whom, to your knowledge, had attended to the patient for this conditon.

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

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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 : _____

Signature _____

Qualification : _____

Date :

_____

Hospital/Clinic Stamp