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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 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

Cardiomyopathy is defined as:

The unequivocal diagnosis by a consultation cardiologist of cardiomyopathy causing impaired ventricular function, suspected by ECG abnormalities and confirmed by cardiac echo of variable aetiology and resulting in permanent physical impairments to the degree of at least class III of the New Work Association Classification of cardiac impairment.

Class III - Marked limitation - Such patients are comfortable at rest but performing less than ordinary activity will lead to symptoms of Congestive Cardiac Failure.
Class IV - Inability to carry out any activity without discomfort. Symptoms of Congestive Cardiac Failure are present even at rest. With any increase in physical activity, discomfort will experience. Cardiomyopathy directly related to alcohol misuse is excluded.

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.

_____

ILLNESS

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

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

_____

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

_____

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

_____

9 Please confirm the diagnosis of Cardiomyopathy.

_____

10 Please give full and exact details of the diagnosis.

_____

11 Kindly advise us the date of diagnosis. ☐☐☐☐☐☐ (DD/MM/YY)

12 Was ECG performed ? ☐ Yes ☐ No, why?_____

13 Was cardiac echo performed ? ☐ Yes ☐ No, why?_____

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14 Please attach results of any investigations performed (eg. Electrocardiogram (ECG) , Echocardiogram (ECHO), chest x-ray ,coronary angiography, cardiac catheterisation) and provide remarks , if any below.

15 Is there impaired ventricular function due to the cardiomyopathy.
If yes, please provide the details.

16 Please provide details of the degree of physical impairment in accordance to New York Association Classification of cardiac impairment.

17 Was the cardiomyopathy directly related to alcohol? ☐ Yes ☐ No

18 What treatment is being rendered and what type of medication are being prescribed?

19 Please comment on the response to treatment

20 Please give the precise prognosis of the condition

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

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

GENERAL INFORMATION

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

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

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

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

Date of Consultation	Disease/Injury

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

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

_____

_____

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