

**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

Heart Attack is defined as:

The death of portion of the heart muscle (myocardium) as a result of inadequate blood supply to relevant area and being evidenced by :-

- i a history of typical prolonged chest pain,
- ii new ECG changes resulting from the occurrence,
- iii elevation of cardiac enzymes (CPK-MB) above the generally accepted laboratory levels of normal.

Diagnosis based on the elevation of Troponin T test alone shall not be considered diagnostic of a heart attack. Agina is specifically 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.

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 (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 myocardial infarction.

- 10 Kindly advise us the date of diagnosis.

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 (DD/MM/YY)

- 11 Please give full details of any chest pain.

- 12 Was an ECG performed ? If so, please give date and details of any new ECG changes.

13 Were cardiac enzymes measured ? If so, please give details of type and levels

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

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

GENERAL INFORMATION

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

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

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

19 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
_____	_____
_____	_____
_____	_____

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

21 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.

Signature
Date :

Name of Doctor : _____
Qualification : _____

Hospital/Clinic Stamp