Section IV - Attending Physician Statement (Critical Illness Claims-Cancer)

Claim No: _____ Policy No: _____

The completion of this form is at the expense of the patient.

Patient's Information	
Name:	IC No:
Date of Admission:	Date of Discharge:
Patient's Medical Information	
1) Please provide full and exact details of the diagnosis.	2) Was the patient referred by any other doctor or hospital? ☐ Yes ☐ No If yes, please state name of the doctor and hospital.
3) Date of injury or symptom(s) first appeared: (DD/MM/YY)	Date when patient consulted you for Cancer: (DD/MM/YY)
4) Are you the patient's usual medical doctor? If **YES**, since when? (DD/MM/YY)	
5)To your best knowledge, has the patient ever had the same or similar condition(s) or symptom(s)? If yes, please state dates and conditions/symptoms:	6) Was the condition caused by any underlying disease? If yes, please specify:
7) Date when Cancer was FIRST diagnosed: (DD/MM/YY)	8) Diagnosis was first made by (name of Doctor):
If the patient had a surgical procedure, please fill in the boxes below:	
9) Name and nature of the procedure:	Date of operation (DD/MM/YY)

Please tick (/) and complete the relevant sections (if applicable):

Gender- Specific Cancer:

	Breast Cancer
	Prostate Cancer
	Testicular Cancer
	Penile Cancer
	Cervical Cancer

	Fallopian Tube Cancer
	Uterine Cancer
	Vaginal Cancer
	Vulvar Cancer
	Ovarian Cancer

10) Details of the patient's illness :

a) Please provide full and exact details of the diagnosis, the site involved and the precise histology of the tumour.

_____

_____

b) Please describe the extent of the disease:

i) Is the tumour : ☐ benign ☐ malignant

ii) What is the staging of the tumour?

_____

iii) Please state the tumour classification (e.g. TMN classification etc).

_____

iv) Was there the uncontrolled growth of malignant cell and invasion of tissue? ☐ Yes ☐ No

c) Please confirm the following :

i) Was there a non-invasive Cancer? ☐ Yes ☐ No

ii) Was there regional or distant spread? ☐ Yes ☐ No

iii) If "Yes", please describe degree of regional nodal involvement, and/or extent of distant spread.

d) What is the nature of treatment?

☐ Surgical ☐ Chemotherapy ☐ Radiotherapy ☐ Palliative

i) Has the patient underwent other mode of treatment? ☐ Yes ☐ No

ii) If YES, please state mode of treatment and the date of treatment. (DD/MM/YY)

11) Was a biopsy of the tumour performed?

☐ Yes ☐ No

12) What is the prognosis of the patient?

13) If there is any further information which is in your opinion will assist us in assessing the claim, please furnish us such information.

Please enclose copies of all reports including biopsy reports,cytology reports, X-Rays, CT Scans, other Imaging Studies, Laboratory Evidence, Surgical Reports and any relevant hospital reports that are available.

Declaration

I hereby certify that the facts given above are true to the best knowledge.

Signature and Stamp:	Name of attending physician/specialist:	Date:
Qualification:	Telephone No:	Hospital: