Section IV - Attending Physician Statement (Nerve and Muscle Related Claims)

(Applicable to Parkinson's Disease, Muscular Dystrophy, Coma, Paralysis of Limbs or Elephantiasis)

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: (a) Date of first consultation with you: (DD/MM/YY) (b) Reasons for referral?
3) Date of injury or symptom(s) first appeared: (DD/MM/YY)	
4) Please state the symptoms presented during the first consultation: a) How long had the symptoms/complaints existed: (i) According to the patient? ______________Day/s__________Week/s________Month/s________Year/s (ii) In your medical opinion? ______________Day/s__________Week/s________Month/s________Year/s	
5) What was the underlying cause? (Please tick in the box, if applicable) ☐ Idiopathic ☐ Alcohol abuse ☐ Autoimmune ☐ Toxin ☐ Trauma ☐ Infection ☐ Drug abuse ☐ Others:________________	6) To your best knowledge, has the patient ever had the same or similar condition (s) or symptom (s) ? ☐ Yes ☐ No If yes, please state dates and conditions/symptoms

7) Please complete this portion (tick (/) where applicable), if patient was diagnosed with any of the illnesses below:

☐ **Parkinson's Disease** - resulting in Permanent inability to perform Activities of Daily Living.
The diagnosis must be confirmed by a Consultant Neurologist.

(i) Can the condition/illness be controlled with medication?
☐ Yes ☐ No

(ii) Are there signs of progressive impairment?
☐ Yes ☐ No

(iii) Is the patient able to perform the following without any assistance? Please tick (/) where applicable:

- ☐ Getting in and out of a chair without requiring physical assistance
- ☐ The ability to move from room to room without requiring any physical assistance
- ☐ The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene
- ☐ Putting on and taking off all necessary items of clothings without requiring any assistance of another person
- ☐ The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means
- ☐ All tasks of getting food into the body once it has been prepared

☐ **Muscular Dystrophy**
Please tick (/) if the patient met the following criteria:

- ☐ Clinical presentation of progressive muscle weakness
- ☐ No central/ peripheral nerve involvement as evidenced by absence of sensory disturbance
- ☐ Characteristic electromyogram and muscle biopsy findings

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☐ **Coma** resulting in Permanent neurological deficit with persisting clinical symptoms.

(i) Is there any reaction or response to external stimuli?
☐ Yes ☐ No

(ii) Is there an internal needs of persisting continuously with the use of a life support system for a period of at least 96 hours?
☐ Yes ☐ No

Taken off:

Date: ____________________ (DD/MM/YY)

Time: ____________________ (A.M/P.M)

(iii) Are there evidence of any permanent neurological deficits of more than 30 days?
☐ Yes ☐ No

If "Yes", kindly provide details.

____

____

(iv) What is the extent of coma under the Glasgow Coma Scale?

____

____

(v) Was the coma resulting from any of the following?

☐ Self-inflicted injury
☐ Medically induced
☐ None of the above

☐ **Paralysis of Limbs**

(i) What are the areas of involvement?

____

____

(ii) What is the cause of the Paralysis?

____

____

(iii) Is the loss of use of the involved limbs considered complete and permanent?
☐ Yes ☐ No

If "Yes", please provide bases for prognosis:

____

____

(iv) Date of last consultation? (DD/MM/YY)

____

☐ **Elephantiasis**
Please tick (/) if the patient met the following criteria:

☐ massive swelling in the tissues of the body as a result of obstructed circulation in the blood or lymphatic vessels.

☐ unequivocal Diagnosis of Elephantiasis was clinically confirmed by laboratory confirmation of microfilariae and be supported by the Company's doctor.

Note: Lymphedema caused by infection with a sexual transmitted disease, trauma, post-operative scarring, congestive heart failure or congenital lymphatic system abnormalities is excluded.

8) Has the Patient suffered from or/been treated for any other illnesses or complaints other than this critical illness?
☐ Yes ☐ No

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

Please enclose copies of ALL the relevant Laboratory evidences/tests for the respective critical illness claim.

(i)	Parkinson's Disease	All Neurological reports, x-rays, CT Scans, and other imaging studies, laboratory evidence, cerebral angiogram and any relevant reports that is available
(ii)	Coma	All post operative reports, x-rays, CT Scans, and any other imaging studies, laboratory evidence, angiograms, etc and any relevant hospital reports that are available
(iii)	Paralysis of limbs	All Neurological reports, x-rays, CT Scans, MRI and any other studies, laboratory tests, surgical reports and any relevant reports that are available
(iv)	Elephantiasis	Laboratory test confirmation of microfilariae and any other relevant reports that are available
(v)	Muscular Dystrophy	Electromyogram and muscle biopsy report, any other relevant studies and 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: