ATTENDING PHYSICIAN'S STATEMENT
HEART ATTACK / CARDIOMYOPATHY / PERICARDIAL DISEASE / CARDIAC ARRYTHMIA

A) Patient's Particulars

Name of Patient	Gender
NRIC/FIN or Passport No.	Date of Birth (ddmmyyyy)

B) Patient's Medical Records

1) Please state over what period does the Hospital/Clinic's record extend?
   (i) Date of first consultation (ddmmyyyy)
   (ii) Date of last consultation (ddmmyyyy)
   (iii) Number of consultations during the above period:
   (iv) Name of hospital/clinic and Reasons for consultations (with dates):

2) Are you the patient's usual medical doctor? ❒ Yes ❒ No
   If "Yes", since when? (ddmmyyyy)
   If "No", please provide name and address of the patient's regular doctor.

3) Was the patient referred to you? ❒ Yes ❒ No
   If "Yes", please provide:
   (i) Date referred (ddmmyyyy)
   (ii) Reason the patient was referred:
   (iii) Name and address of doctor recommending the referral:
   If "No", how did the patient come to consult at your hospital/clinic? (e.g. A&E.)

4) Have you referred the patient to any other doctor? ❒ Yes ❒ No
   (i) Date referred (ddmmyyyy)
   (ii) Reason for referral:
   (iii) Name and address of doctor referred to:

5) Does the patient have or ever have had any significant health conditions, medical history or any illness (e.g. hyperlipidaemia, hypertension, angina, hepatitis, diabetes, tumour, etc.)? If "Yes", please provide: ❒ Yes ❒ No

Details of symptoms	Exact diagnosis	Date diagnosed	Treatment

6) Name and address of doctor whom the patient consulted for the condition(s) stated in Question 5 above.

7) What is your source of the above information?

8) Please give details of the patient's habits in relation to past and present **smoking**, including the duration of smoking habits, number of cigarettes smoked per day and source of this information:

No. of years of smoking	No. of sticks per day	Source of information

9) Please give details of the patient's habits in relation to **alcohol consumption**, including the amount of the alcohol consumption, frequency and the source of this information.

Type of alcohol	Quantity per Consumption	Frequency (per week / month, etc)	Source of information

C) Details of Illness

1) Please provide details of **Heart Attack**:

(i) Date of first consultation for this condition (ddmmyyyy)

(ii) Details of symptom(s) presented during the first consultation, and date these symptoms **first** started.

(iii) What is the underlying cause(s) of the symptoms?

(iv) Exact Diagnosis of the condition:

ICD-10 Code (if applicable):

(v) Date of first diagnosis (ddmmyyyy)

(vi) Date the patient first became aware of the illness/condition (ddmmyyyy)

2) Please provide dates and details of investigation performed for the diagnosis and attach a copy of all relevant test reports which confirmed the diagnosis.

3) Name and address of the doctor / cardiologist who **first** diagnosed the patient with this condition.

4) Has the patient previously suffered from a Heart Attack or any related illnesses (e.g. hypertension, angina or other vascular disease? If "Yes", please provide details: ❒ Yes ❒ No

Date of First diagnosis	Exact diagnosis	Name of doctor and Address of hospital/clinic

5) Please describe the initial episode:

(i) Nature of episode:

(ii) Date of initial episode (ddmmyyyy)

(iii) Duration of acute symptoms:

6) Please confirm the following.

If "**Yes**" to any question, please **elaborate** with supporting evidence including date of test and test results.

(i) Was there a current history of typical chest pain? ❒ Yes ❒ No

(ii) Were there any changes in the ECG indicative of new myocardial infarct? ❒ Yes ❒ No

If "Yes", please state whether there was any:

(a) ST elevation or depression? ❒ Yes ❒ No

(b) T wave inversion? ❒ Yes ❒ No

(c) Pathological Q waves? ❒ Yes ❒ No

(d) Left bundle branch block? ❒ Yes ❒ No

Please **attach** a copy of the ECG tracing report.

7) Was there a diagnostic elevation of cardiac biomarkers, such as CKMB, Troponin T or I, etc.? ❒ Yes ❒ No

If "Yes", please provide type and date of test, and test results. **Attach** a copy of the laboratory results:

Type of Cardiac biomarker	Date & time of test (***before*** any cardiac procedure)	Test Results (specify the units)
	Date & time of test (***after*** cardiac procedure, if any)	Test Results (specify the units)

8) Please advise with regard to the left ventricular ejection fraction:

(i) Was there left ventricular ejection fraction of less than 50% measured three months or more after the event? ❐ Yes ❐ No

(ii) What was the left ventricular ejection fraction at initial diagnosis?

9) Was there death of a portion of the heart muscle? ❐ Yes ❐ No

If "Yes", please provide details.

10) Was there imaging evidence of new loss of viable myocardium or new regional wall motion abnormality? ❐ Yes ❐ No

If "Yes", please elaborate with supporting evidence of imaging reports and name of the attending cardiologist.

11) Please provide details of the surgery and/or other mode of treatment that had been performed, including name and date of treatment, and name and address of attending cardiologist.

12) Date of return to normal activities (ddmmyyyy)

13) Has the patient suffered from **Cardiomyopathy** condition? ❐ Yes ❐ No

If "No", please proceed to **Question 14**.

If "Yes", please proceed as follows:

(i) Date of first diagnosis of Cardiomyopathy (ddmmyyyy)

(ii) Has the patient previously undergone any cardiac investigation (e.g. ECG, echocardiogram, CT scan, etc.)? ❐ Yes ❐ No

If "Yes", please advise:

(a) Type of cardiac investigation done:

(b) Date of investigation (ddmmyyyy)

Please **attach** a copy of the above investigation reports.

(iii) Was the diagnosis of cardiomyopathy made unequivocally by cardiac echocardiogram? ❐ Yes ❐ No

If "Yes", please attach a copy of the echocardiogram report.

If "No", please specify the basis of diagnosis.

(iv) Does the patient have any cardiac or physical impairment which fulfills the New York Heart Association (NYHA) Classification of Cardiac Impairment criteria? ❒ Yes ❒ No

If “Yes”, please describe the patient’s current symptoms.

Please state the NYHA class of impairment? (delete as appropriate): **Class I / II / III / IV**

(v) Is the patient’s cardiomyopathy condition related to:

(a) Alcohol misuse? ❒ Yes ❒ No

(b) Drug misuse? ❒ Yes ❒ No

If “Yes”, please provide details of alcohol/drug consumption, including the amount, frequency and types of consumption.

14) Has the patient suffered from **Pericardial disease** condition? ❒ Yes ❒ No

If “No”, please proceed to **Question 15**.

If “Yes”, please advise the following:

(i) Date of first diagnosis of Pericardial disease (ddmmyyyy)

(ii) Was surgery performed for the patient’s pericardial disease condition? ❒ Yes ❒ No

If “Yes”, please advise:

(a) Type of surgery performed (e.g. pericardectomy, keyhole cardiac surgery, etc.):

(b) Date of surgery (ddmmyyyy)

Please **attach** a copy of the above investigation reports.

(iii) Was the surgery performed considered medically necessary by the consultant cardiologist? ❒ Yes ❒ No

(iv) Was there any other mode of treatment other than the above surgery that could have been performed? ❒ Yes ❒ No

If "Yes”, please specify:

(a) Alternate mode of treatment.

(b) Reasons why the above alternate mode of treatment was not used.

15) Has the patient suffered from **Cardiac Arrhythmia**? ❒ Yes ❒ No

If "No", please proceed to **Section D**.

If "Yes", please attach a copy of the ECG tracing and advise:

(i) Type of cardiac arrhythmia presented:

(ii) Date of first diagnosis (ddmmyyyy)

(iii) Was pathway ablation therapy attempted? ❒ Yes ❒ No

If "Yes", please state the date of therapy (ddmmyyyy)

If "No", why was this not done?

(iv) Was a permanent cardiac pacemaker inserted? ❒ Yes ❒ No

If "Yes", please state the date of insertion (ddmmyyyy)

(v) Was a permanent cardiac defibrillator inserted? ❒ Yes ❒ No

If "Yes", please state the date of insertion (ddmmyyyy)

(vi) Was there any other mode of treatment which could have been used to treat the patient's cardiac arrhythmia? If "Yes", please specify: ❒ Yes ❒ No

(a) Alternate mode of treatment.

(b) Reasons why the above alternate mode of treatment was not used.

D) Other Information

1) What is the prognosis of the patient's condition?

2) Has the patient **previously** had any cardiac investigation done (e.g. ECG, echocardiogram, CT scan)? ❒ Yes ❒ No

If "Yes", please provide details:

(i) Type, results and date of cardiac investigation done:

(ii) Reasons for the investigation:

(iii) Name of cardiologist and address of hospital / clinic:

3)	Is there anything in the patient's **personal medical history** which would have increased the risk of heart diseases? If "Yes", please provide details: Exact diagnosis Date of diagnosis Name of doctor & address of hospital/clinic	❐ Yes ❐ No
4)	Is there anything in the patient's **family history** which would have increased the risk of Heart disease? If "Yes", please give details: Relationship with patient Nature of condition Age of onset Source of information	❐ Yes ❐ No
5)	Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for **Heart Attack** or any other related diseases? If "Yes", please give details: Name of doctor and address of hospital/clinic Date of first & last consulation Reasons for consultation	❐ Yes ❐ No
6)	Please provide us with any other additional information that will enable the Company to assess this claim.	
7)	Please enclose a copy of all investigations reports including specialist or hospital reports (e.g. cardiac enzyme assays, exercise stress tests, coronary angiography, echocardiography, myocardial perfusion scans, etc.) that are available.	

E) Declaration	
I hereby declare that the above answers are true to the best of my knowledge and belief.	
Signature of Doctor	Address & Offical Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	