Manulife

ATTENDING PHYSICIAN'S STATEMENT (PROSTATE CANCER)

Policy No.
Claim No. (For internal use)

To be completed by the Attending Physician at Insured's expense.

1. PATIENT'S PARTICULARS

Name of the Patient: _____ NRIC/Passport No: _____

Date of Birth: _____ Sex: _____ Admission No: _____ Ward No: _____

Date of Admission: _____ Date of Discharge: _____

2. DETAILS OF PATIENT'S CONDITION

In order for a claim under this policy to be paid, the following definition must be satisfied:

Prostate cancer means a malignant tumour primarily located in the prostate and characterised by the uncontrolled growth and spread of malignant cells and invasion of the tissue. Such cancer must be positively diagnosed by a specialist pathologist upon the basis of a microscopic examination of fixed tissues. Such diagnosis shall be based solely on the accepted criteria of malignancy after a study of the histocytologic architecture or pattern of the suspect tumour, tissue or specimen. Clinical diagnosis does not meet the criteria.

The following are excluded:
(a) all tumours which are histologically described as less than or equivalent to TNM classification T1 (including T1a and T1b) or pre-malignant or as non-invasive or as cancer-in-situ;
(b) all metastatic cancer to the prostate;
(c) all tumours which are invasion from surrounding structures or organs.

(a) Please describe the exact details of the patient's condition.

_____

_____

_____

_____

_____

_____

_____

(b) Date you were first consulted for the condition: _____/ _____/ _____
dd mm yyyy

(c) What are the signs or symptoms presented at that time?

Signs or Symptoms presented	Date first appeared

(d) What was the diagnosis?

_____

_____

_____

(e) Date when the condition was first diagnosed: _____/ _____/ _____
dd mm yyyy

(f) Date when the patient first became aware of the condition: _____/ _____/ _____
dd mm yyyy

(g) Has the patient suffered any previous episodes of the underlying condition or any other condition leading to or relating to it? If yes, please give details. □ Yes □ No

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_____

(h) 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. □ Yes □ No

_____

_____

(i) Please confirm the diagnosis of Prostate Cancer.

_____

_____

_____

_____

(j) Please give histology and staging of the tumour.

_____

_____

_____

(k) Is the prostate the primary site of origin? □ Yes □ No

If no, please state the primary site of origin.

_____

_____

_____

(l) Type of surgery performed: _____

(m) Date of surgery: _____/ _____/ _____
dd mm yyyy

(n) Name and address of Hospital: _____

_____

(o) Name and address of the Doctor who performed the surgery.

_____

_____

_____

(p) Please give full details of all investigations performed in relation to this condition and their results.

_____

_____

_____

_____

_____

(q) Please give details of the patient's habits in relation to alcohol, cigarette smoking and drug addiction, both past and present.

_____

_____

_____

3. MEDICAL HISTORY

(a) If the patient was referred from a clinic or hospital, please state:

(i) Name of referral doctor: _____

(ii) Name of clinic/ hospital: _____

(iii) Date referred: _____

(b) Did the patient consult other doctors for this illness or its symptoms before he/ she consulted you?

□ Yes □ No

If yes, please provide the name(s) and address(es) of the doctor(s) whom he/ she consulted.

Name of Doctor	Name of Clinic/ Hospital and Address	Dates of Consultation

(c) Is the patient suffering or has suffered from any other significant illnesses? □ Yes □ No

If yes, please provide the following information to us.

Illness	Date of first Diagnosis	Name and Address of Attending Doctor

(d) Did you refer the patient to any other doctor(s)? □ Yes □ No

If yes, please provide the name and address of the doctor(s).

_____

_____

_____

(e) Please give any other information which you feel would be helpful in assessment of the patient's claim.

_____

_____

_____

Please enclose copies of specialist or hospital reports together with any tests or similar evidence to support the validity of the patient's claim.

Signature of Doctor

Date

Name and Qualification (printed)

Address & Official Stamp