Manulife

ATTENDING PHYSICIAN'S STATEMENT
ANGIOPLASTY AND OTHER INVASIVE TREATMENT FOR CORONARY ARTERY

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. tumour, hepatitis, hyperlipidaemia, hypertension, diabetes, etc.)? ❒ Yes ❒ No

If "Yes", please provide:

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 the heart disease that led to **Coronary Angioplasty or similar intra-arterial catheter procedure**:

(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) Name and address of the cardiologist who **First** diagnosed the patient with this condition.

3) Please state type of procedure performed.

4) Date the procedure was performed (ddmmyyyy)								

5) Please specify the coronary arteries involved and the degree (%) of narrowing, and **attach** a copy of **Angiogram report**.

Coronary Artery	Stenosis	Percentage of Stenosis
Left Main Stem	❒ Yes ❒ No	
Left Anterior Descending Artery	❒ Yes ❒ No	
Left Circumflex Artery	❒ Yes ❒ No	
Right Coronary Artery	❒ Yes ❒ No	

6) Name of surgeon who performed the procedure and name of hospital in which it was performed.

7) Please provide full details of any other treatment provided.

8) Was the procedure considered medically necessary by the consultant cardiologist? ❒ Yes ❒ No

9) Has the patient undergone a similar procedure before? ❒ Yes ❒ No

If "Yes", please state date and place where it was performed, and the reason(s) for the procedure.

10) Did the patient previously suffer from coronary artery disease or any related illness? ❒ Yes ❒ No

If "Yes", please provide details including date of diagnosis, exact diagnosis, treatment prescribed, and name and address of attending doctor.

11) Have any other investigative tests or procedure been performed? ❒ Yes ❒ No

If "Yes", please provide details and attach a copy of results (e.g. angioplasty operation report, myocardial perfusion test, 2-D echocardiogram, etc).

D) Other Information

1) Is there anything in the patient's **personal medical history** which would have increased the risk of Coronery Artery Disease? If "Yes", please give details: ❒ Yes ❒ No

Exact diagnosis	Date of diagnosis	Name of doctor & Address of hospital/clinic

2) Is there anything in the patient's **family history** which would have increased the risk of Coronery Artery Disease? If "Yes", please give details: ❒ Yes ❒ No

Relationship with patient	Nature of condition	Age of onset	Source of information

3) Please describe and elaborate on the nature and severity of the patient's disability and limitation, if any.

4) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient has also consulted for **Coronery Artery Disease** or any other related diseases? ❒ Yes ❒ No

If "Yes", please give details:

Name of doctor and Address of hospital/clinic	Date first & last consulted	Reasons for consultation

5) Is the patient still on follow-up? ❒ Yes ❒ No

If "Yes", please state date of next appointment (ddmmyyyy) | | | | | | | | |

If "No", please state date of discharge (ddmmyyyy) | | | | | | | | |

6) Please provide us with any other additional information that will enable the Company to assess this claim.

7) Please enclose copies of all reports including specialist or hospital reports (e.g. Exercise stress tests, cardiac enzyme assays, coronary angiography, echocardiography, surgical reports, X-rays, CT scans, myocardial perfusion scans, and any other imaging studies, laboratory evidence, etc) and any relevant hospital reports 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)	