Manulife

ATTENDING PHYSICIAN'S STATEMENT (ECTOPIC PREGNANCY)

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:

Ectopic Pregnancy means pregnancy in which implantation of a fertilised ovum occurs outside the uterine cavity.

(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 symptoms did the patient complain of when she first saw you for this condition?

_____

_____

_____

_____

(d) According to the patient, how long has she been experiencing these symptoms?

_____

_____

(e) For how long do you think the patient has actually experienced these symptoms?

_____

_____

(f) What was the diagnosis?

_____

_____

_____

_____

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

(h) 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.

_____

_____

_____

_____

(i) Please confirm the diagnosis of Ectopic Pregnancy as described above.

_____

_____

_____

(j) Please state the duration of pregnancy: _____

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

_____

_____

_____

_____

_____

(l) Please give the full details of the operation performed.

_____

_____

_____

_____

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

(n) Please advise the name and address of the doctor who has confirmed the diagnosis of Ectopic Pregnancy.

_____

_____

_____

(o) 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 she consulted you?

□ Yes □ No

If yes, please provide the name(s) and address(es) of the doctor(s) whom 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) Are you the patient's regular doctor? □ Yes □ No

If yes, since when? _____/ _____/ _____
dd mm yyyy

If no, please provide the name and address of the patient's regular doctor.

_____

_____

(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

Address & Official Stamp

Name and Qualification (printed)

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