

ATTENDING PHYSICIAN'S STATEMENT (LEUKAEMIA)

Policy No.
Claim No. <small>(For internal use)</small>

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:

Leukaemia means a disease characterised by neoplastic proliferation of blood-forming cells manifested as permanent increase in the number of immature or abnormal white blood cells. The diagnosis must be made by a consultant haematologist and must be confirmed by pathological tests. Chronic Lymphocytic Leukaemia Binet Stages A and B or Rai stages O, I and II are excluded.

(a) Please describe in close detail 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

(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

Manulife (Singapore) Pte Ltd.

Reg. No. 198002116D

Main Office: 8 Cross Street #15-01, Manulife Tower, Singapore 048424

Tel: 67371221 Website: www.manulife.com.sg