Manulife

ATTENDING PHYSICIAN'S STATEMENT (SKIN TRANSPLANTATION DUE TO ACCIDENTAL BURNING)

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:

Skin transplantation due to accidental burning means the undergoing of skin transplantation for facial disfigurement due to accidental burning, or the undergoing of skin transplantation due to accidental burning affecting at least 10% of the body surface area as measured by the Lund or Browder Body Surface Chart.

(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) Date of incident resulting in major burns: _____/ _____/ _____
dd mm yyyy

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(e) Where did the incident occur?

_____

_____

_____

(f) Please advise the circumstances leading to the burns occurring.

_____

_____

_____

_____

(g) In your opinion, is there a possibility that the burns were self- inflicted? □ Yes □ No

If yes, please state your reasons.

_____

_____

(h) Has the patient previously suffered from the condition specified above or any related condition?

If yes, please state the dates and situations resulting in prior burns. □ Yes □ No

_____

_____

_____

_____

(i) Is there anything in the patient's habits or personal history which would increase the risk of accidents or burns? If yes, please give details. □ Yes □ No

_____

_____

_____

(j) Please confirm the diagnosis.

_____

_____

_____

(k) Please describe the exact percentage of the body surface area affected.

_____

_____

_____

(l) Please describe the part(s) of the body affected.

_____

_____

_____

(m) Type of surgery performed: _____

(n) Was surgery required for this condition? □ Yes □ No

If yes, please state the reason(s) of surgery.

_____

_____

_____

_____

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

(p) Name and address of Hospital: _____

_____

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

_____

_____

_____

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

_____

_____

_____

_____

_____

(s) 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 condition 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) 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