HSBC Life

Attending Physician Statement - Chronic Lung Disease or End Stage Lung Disease

Instruction to doctor: This patient is insured with us against the happening of certain contingent events associated with his health. A claim has been submitted in connection with Chronic or lung disease or End stage lung disease. To enable us to assess the claim, please complete this report and return it directly to our company. For questions where date is applicable, please complete in the format of day/month/year.

To be completed and signed by the Attending Physician

I hereby certify that I personally examined the patient and my records and medical opinion are as follows:

1. Name of patient: _____ NRIC no. : _____

2. Are you the patient's regular medical attendant? ☐ Yes ☐ No
If yes, please provide details beginning with the first record in your clinic:

Date(s) consulted	Purpose & details of Consultation(s)	Diagnosis	Nature of treatment rendered, including type of tests and/or surgeries done

If no, do you know the name and address of the patient's regular medical attendant(s)? ☐ Yes ☐ No

If yes, please provide details:

Name of medical attendant	Address

3. Details of the consultation

3.1 Date you were first consulted for lung condition or end-stage lung disease or pulmonary emboli (state the condition consulted).

_____

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3.2 State the symptoms presented, the medical history as presented by the patient and date when the symptoms first appeared.

Symptoms Presented at first consultation	Date symptoms first started

3.3 Where is the source of this information about the patient's condition? (Patient or referring doctor or others. If others, please specify)

_____

3.4 In your opinion, how long do you think the symptoms first appeared prior to consulting you?

_____

3.5 If the patient was referred to you OR if the patient had seen other doctor(s) before consulting you for this medical condition or its symptoms, please provide details:

Name of doctor(s) or hospital(s)	Address of doctor(s) or hospital(s)	Date consulted or date referred to you

(Please continue with your documentation on a blank page if there are more than 3 records and attached it with this report)

4. Details of the illness

4.1 Details of diagnosis:

Doctor's diagnosis	
Diagnosis date	
Underlying cause (if any)	

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4.2 Date of when patient was first informed of the diagnosis: _____

4.3 Name of doctor or hospital who first made the diagnosis:

_____

4.4 & 4.5 are additional questions for severe asthma & pulmonary emboli

4.4 Does the patient has persistent status asthmaticus? ☐ Yes ☐ No

If yes,

(i) Does the patient requires hospitalisation? ☐ Yes ☐ No

(ii) Does the patient requires assisted ventilation with a mechanical ventilator for a continuous period of at least 4 hours? ☐ Yes ☐ No

4.5 Does the patient has pulmonary emboli? ☐ Yes ☐ No

If yes,

(i) Please provide the date of any subsequent pulmonary embolism. (Please provide dates of every recurrence)

Date	Diagnosis	Treatment provided	Name & address of doctors consulted

(Please continue with your documentation on a blank page if there are more than 4 recurrences and attached it with this report)

(ii) Does the patient requires surgical insertion of a vena caval filter? ☐ Yes ☐ No

(iii) Is there other alternate treatment which could also treat the patient's condition? ☐ Yes ☐ No

If yes, please state the type of alternate treatment and the reason why was this treatment not undertaken.

_____

4.6 to 4.7 are additional questions for end stage lung disease

4.6 Is there end-stage lung disease causing chronic respiratory failure? ☐ Yes ☐ No

If yes, please state the date when end-stage lung disease was first diagnosed.

_____

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4.7 Has the diagnosis of end stage lung disease been supported by evidence of all of the following?

(a) FEV1 test results which are consistently less than 1 litre ☐ Yes ☐ No

(b) Patient has received extensive and permanent supplementary oxygen therapy for hypoxemia. ☐ Yes ☐ No
If yes, please provide the start date of such therapy: _____

(c) Dyspnea at rest ☐ Yes ☐ No

(d) Arterial blood gas analyses with partial oxygen pressures of 55mmHg or less ($PaO_2 \leq 55$ mmHg) ☐ Yes ☐ No

(e) Diagnosed and confirmed by a respiratory physician ☐ Yes ☐ No

4.8 Was the above diagnosis and/or surgical operation supported by histological, radiological or laboratory evidence and confirmed by a specialist of the relevant field? ☐ Yes ☐ No

- If yes, please state mode of investigation done to establish the above diagnosis and attach copies of histological, radiological, laboratory results and operation reports.

- If no, why and on what basis did you derive at such diagnosis?

_____

4.9 Is the patient's condition or surgery performed in any way related or due to:

(a) AIDS or HIV related illness? ☐ Yes ☐ No

(b) Use of drug not prescribed by a registered medical practitioner or drug abuse? ☐ Yes ☐ No

(c) Alcohol abuse? ☐ Yes ☐ No

(d) Attempted suicide or self-inflicted injuries? ☐ Yes ☐ No

If yes for (a) to (c), please provide details and enclose a copy of the test result:

Diagnosis date	
Name and address of doctor who first diagnosed the patient with HIV, AIDS, drug abuse or alcohol abuse	

5. Details of treatment and surgery

5.1 State the full details of all treatment provided (example medication, therapy).

Nature of treatment	Date(s) of treatment

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5.2 Was there any surgery performed or going to be performed? ☐ Yes ☐ No
If yes, please provide details and enclose a copy of the operation report.

Nature of surgery performed or going to be performed	Date(s) of surgery

5.3 Patient's response to the treatment: _____

5.4 Was the patient referred to other doctor(s) for follow up or further management?
☐ Yes ☐ No

If yes, please state name and address of doctor(s) or hospital(s) and the reason(s) for referral.
_____

5.5 Is the patient still on follow up treatment with you? ☐ Yes ☐ No
If yes, please state the follow up treatment plan.

_____

5.6 is an additional question for pneumonectomy or complete surgical removal of a lung

5.6 Was there pneumonectomy done? ☐ Yes ☐ No
If yes, please provide details:
(i) Reason for requiring this surgery.

_____

(ii) Was the surgery absolutely necessary? ☐ Yes ☐ No

(iii) Was it a partial or complete removal of lung?
❑ Partial ❑ Complete

(iv) Is there other alternate treatment which could also treat the condition? ☐ Yes ☐ No
If yes, please state the type of alternate treatment and the reason why was this treatment not undertaken.

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6. Regarding the patient's medical history

6.1 Has this patient *previously* suffered from the same condition or any related illnesses? ☐ Yes ☐ No

If yes, please provide details:

Date of when condition was first diagnosed	
Resulting diagnosis	
Name and address of doctor who attended to patient (if not attended to by you).	

6.2 Is the patient suffering from or suffered from any other medical conditions? ☐ Yes ☐ No
If yes, please provide details:

Name of doctor(s) or hospital(s) & Address	Diagnosis	Diagnosis date	Nature of treatment rendered, including type of tests and/or surgeries done

(Please continue with your documentation on a blank page if there are more than 4 records and attached it with this report)

6.3 Is there anything in the patient's personal medical history which would have increased the risk of lung disease? ☐ Yes ☐ No
If yes, please provide full details, including the date of diagnosis, name and address of attending doctor and source of information.

_____

6.4 Is there anything in the patient's family history which would have increased the risk of lung disease? ☐ Yes ☐ No
If yes, please provide full details, including relationship, nature of illness, date of diagnosis and source of information.

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6.5 Please provide details of the patient's habits in relation to cigarette smoking, including the duration of the smoking habit, number of cigarettes smoked per day and source of information.

_____

6.6 Please provide details of the patient's habits in relation to alcohol consumption, including the amount of alcohol consumption per day and source of information.

_____

7. Please provide us with any other additional information that will enable us in assessing this claim.

_____

_____ _____

Date Name and signature of doctor

_____ _____

Address and official stamp Qualifications