HSBC Life

# Attending Physician Statement - HIV Due to Blood Transfusion

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 HIV due to blood transfusion. 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 AIDS / HIV (Human Immunodeficieny Virus): _____

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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 (as HIV positive) | |
| Underlying cause (if any) | |

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

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

_____

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4.4 Please provide details of the history of this condition.

_____

4.5 Please provide dates and results of all HIV and antibody tests done.

_____

_____

4.6 Was the cause of HIV infection due to blood transfusion? ☐ Yes ☐ No
If yes, please provide details.
(a) Why was the patient receiving blood transfusion?

_____

(b) Name and address of the hospital where the transfusion took place.

_____

(c) On what date did the blood transfusion take place?

_____

(d) Was the blood transfusion medically necessary and given as part of a medical treatment the patient? ☐ Yes ☐ No

(e) Has the source of infection established to be from the hospital that provided the blood transfusion? ☐ Yes ☐ No

(f) Was the hospital able to tract the origin of the HIV tainted blood? ☐ Yes ☐ No

If yes, please provide details.

_____

(g) Was the patient suffering from Thalassaemia Major or Haemophillia? ☐ Yes ☐ No

If yes, please provide date of diagnosis, name and address of doctor consulted and nature of tests performed, date of tests performed and their results.

_____

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4.7 Did the patient belong to any of the follow groups?

| | | | |
|---|---|---|---|
| i. | Homosexual and bisexual men | ☐ Yes | ☐ No |
| ii. | Intravenous drug user | ☐ Yes | ☐ No |
| iii. | Haemophilia | ☐ Yes | ☐ No |
| iv. | Spouses and sexual partners of the above groups | ☐ Yes | ☐ No |

4.8 Was the diagnosis of HIV (due to blood transfusion) supported by laboratory, diagnostic or imaging evidence and confirmed by a specialist of the relevant field? ☐ Yes ☐ No

(a) If yes, please state mode of investigation done to establish the above diagnosis or surgery and attach copies of all HIV and antibody tests results and other relevant diagnostic results.

_____

(b) If no, why and on what basis did you derive at such diagnosis?

_____

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

| | | |
|---|---|---|
| (a) Sexual activity? | ☐ Yes | ☐ No |
| (b) Use of intravenous drug? | ☐ Yes | ☐ No |
| (c) Inherited since birth? | ☐ Yes | ☐ No |
| (d) Physical assault? | ☐ Yes | ☐ No |
| (c) Organ Transplant? | ☐ Yes | ☐ No |
| If yes, is the organ transplant medically necessary? | ☐ Yes | ☐ No |

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 |
|---|---|
| | |
| | |

5.2 Was 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 |
|---|---|
| | |
| | |

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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.

_____

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)

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6.3 Is there anything in the patient's personal medical history which would have increased the risk of HIV infection? ☐ 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 of risk of HIV infection? ☐ Yes ☐ No
If yes, please provide full details, including relationship, nature of illness, date of diagnosis and source of information

_____

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 Qualification