

## Attending Physician Statement - Rheumatic Fever with Valvular Impairment

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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 Rheumatic fever with valvular impairment. 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 rheumatic fever: \_\_\_\_\_

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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)

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

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- 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 Was the patient's condition diagnosed according to the revised Jones criteria for Acute Rheumatic Fever?  Yes  No

4.5 Did the patient present with any of the major criteria as follows?

- (a) Carditis  Yes  No
- (b) Polyarthrititis  Yes  No
- (c) Chorea (also known as Sydenham's chorea)  Yes  No
- (d) Erythema marginatum (a non-pruritic rash)  Yes  No
- (e) Subcutaneous nodules  Yes  No

If yes to any of the above, please provide details on your findings and the extent of the major criteria involved.

\_\_\_\_\_

\_\_\_\_\_

4.6 Did the patient present with any of the minor criteria as follows?

- (a) Fever  Yes  No
- (b) Arthralgia  Yes  No
- (c) Previous rheumatic fever or rheumatic heart disease  Yes  No
- (d) Acute phase reactants: Leukocytosis, elevated eritrosedimentation rate (ESR) and C-reactive protein (CRP)  Yes  No
- (e) Prolonged P-R interval on electrocardiogram (ECG)  Yes  No

If yes to any of the above, please provide details on your findings and the extent of the minor criteria involved.

\_\_\_\_\_

\_\_\_\_\_

4.7 Was there evidence of recent preceding streptococcal infection?  Yes  No

If yes, does the patient present with any of the following?

- (a) Increased antistreptolysin O or other streptococcal antibodies  Yes  No
- (b) Positive throat culture for Group A beta-hemolytic streptococci  Yes  No
- (c) Positive rapid direct Group A strep carbohydrate antigen test  Yes  No
- (d) Recent scarlet fever  Yes  No
- (e) Others, please specify: \_\_\_\_\_

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4.8 Was there evidence of valve incompetence attributable to rheumatic fever?  Yes  No

4.9 Was there involvement of valvular impairment of 1 or more heart valves?  Yes  No  
If yes, please provide details:

(a) Which heart valve(s) is or are involved?

\_\_\_\_\_

(b) The extent of such valvular impairment.

\_\_\_\_\_

4.10 Was the valve incompetence diagnosed and confirmed by a qualified cardiologist?  Yes  No

If yes, please provide the name and address of the cardiologist.

\_\_\_\_\_

4.11 Was the diagnosis of Rheumatic fever with valvular impairment supported by echocardiograph evidence, ECG, laboratory test, quantitative investigations of valve function or other imaging techniques?  Yes  No

(a) If yes, please state mode of quantitative investigation done to establish the above diagnosis and attach copies of echocardiograph report, resulting ECG, radiological, laboratory blood tests and other relevant reports.

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

4.12 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

If yes, please provide details and enclose a copy of the test result:

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

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

Nature of treatment or surgery	Date(s) of treatment

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.

\_\_\_\_\_

\_\_\_\_\_

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	
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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 rheumatic fever with valvular impairment?  Yes  No

If yes, please provide full details, including the date of diagnosis, name and address of attending doctor and source of information.

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- 6.4 Is there anything in the patient's family history which would have increased the risk of rheumatic fever with valvular impairment?  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.

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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.

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

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Date

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Name and signature of doctor

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Address and official stamp

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Qualifications