HSBC Life

Attending Physician Statement - Severe Asthma

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 Severe Asthma. 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 asthma: _____

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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:

_____

4.5 Is there evidence of acute attack of severe asthma with persistent status asthmaticus? ☐ Yes ☐ No

If yes, please date(s) for such attack(s) and full details.

_____

4.6 Was the patient hospitalised due to asthma? ☐ Yes ☐ No
If yes, please date(s) for admission(s) and name of hospital(s).

_____

4.7 Did the patient require assisted ventilation with a mechanical ventilator to establish control of the asthma attack on the advice of a respiratory physician? ☐ Yes ☐ No
If yes, please provide duration (in hours) of continuous mechanical ventilator administered.

_____

4.8 Does the patient have Harrison's sulcus chest deformities resulting from chronic hyperinflation? ☐ Yes ☐ No

4.9 Does the patient's condition warrant the need for medically prescribed oxygen therapy at home? ☐ Yes ☐ No

4.10 (a) Did the patient's condition require continuous daily use of oral corticosteroids for a minimum period of at least 6 months on the advice of a consultant paediatrician or respiratory physician to control his asthma? ☐ Yes ☐ No
If yes, please provide details.

Name of drug and dosage	
Start date of treatment	
End date of treatment	

(b) Is the therapy still ongoing? ☐ Yes ☐ No

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4.11 (a) Does the patient have significant and persistent limitation of his peak expiratory flow rate? For this purpose, it is defined as maximum peak expiratory flow rate recordings of less than 80% of the rate predicted for a person of the same age, sex and build while taking the treatment prescribed for asthma by a consultant paediatrician or respiratory physician. ☐ Yes ☐ No

(b) Please provide details of the recordings:
(The recordings are to be made on at least 4 occasions at 4 intervals of no less than 1 month in a period of at least 12 months)

Peak expiratory flow rate	Date(s) recorded

(c) Are the above recordings made by a consultant paediatrician or respiratory physician? ☐ Yes ☐ No

(d) Is the patient complying with optimal prescribed asthma medication throughout the period to which the recordings relate? ☐ Yes ☐ No

4.12 If the patient is a child, has the asthma resulted in significant growth impairment? For this purpose, it is defined as height below the third percentile for the child's age and sex in a child with asthma whose height has been previously recorded at or above the fifth percentile at a routine developmental examination at the age of at least one year. ☐ Yes ☐ No

4.13 Was the above diagnosis supported by radiology, lung function tests or 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 and attach copies of lung function tests and radiological reports.

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

_____

4.14 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

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(d) Attempted suicide of 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

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.

_____
_____

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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 severe asthma? ☐ 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 severe asthma? ☐ 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