HSBC Life

Attending Physician Statement - Special Conditions

Instruction to doctor: This patient is insured with us against the happening of certain contingent events associated with his health. To enable us to assess the claim, please complete this report accordingly and return it directly to our company. For questions where date is applicable, please complete in the format of day/month/year.

POLICY NO : _____

Name of patient : _____ NRIC no. : _____

This claim is being filed for the following illness: (Please tick [✓] in the appropriate box)

			Pages to be completed
A	Breast Reconstructive Surgery following a Mastectomy	❑	1-4 & 5
B	Chronic Adrenal Insufficiency (Addison's Disease)	❑	1-4 & 6
C	Chronic Relapsing Pancreatitis	❑	1-4 & 7
D	Dengue Haemorrhagic Fever	❑	1-4 & 8
E	Diabetic Complications including Diabetic Retinopathy, Diabetic Nephropathy or amputation of part of limb due to gangrene	❑	1-4 & 9
F	Osteoporosis	❑	1-4 & 10
G	Pheochromocytoma	❑	1-4 & 11
H	Severe Crohn's Disease	❑	1-4 & 12
I	Severe Rheumatoid Arthritis	❑	1-4 & 13
J	Severe Ulcerative Colitis	❑	1-4 & 14
K	Wilson's Disease	❑	1-4 & 15

To be completed and signed by the Attending Physician

1. 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

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2. Details of the consultation

2.1 Date you were first consulted for patient's medical condition: : _____

2.2 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

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

_____

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

_____

2.5 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)

3. Details of the illness

3.1 Details of diagnosis:

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

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

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

_____

4. Details of treatment and surgery

4.1 State the full details of all treatment provided (example medication, chemotherapy, radiotherapy).

Nature of treatment	Date(s) of treatment

4.2 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

5.4 Patient's response to the treatment: _____

5.5 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.

_____

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

_____
_____

5. Regarding the patient's medical history

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

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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).	

5.2 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 3 records and attached it with this report)

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

_____

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

_____

5.5 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.

_____

5.6 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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A. Breast Reconstructive Surgery following a Mastectomy

1. What was the site or organ involved and the precise histology of the tumour?

_____

2. What is the staging of the tumour? Please provide full details using appropriate staging classification (e.g. TMN classification etc).

_____

3. Was the disease completely localised? ☐ Yes ☐ No

4. Was there invasion to the surrounding or adjacent tissues? ☐ Yes ☐ No
If yes, please state the sites or tissues which showed evidence of invasion.

_____

5. Were regional lymph nodes involved? ☐ Yes ☐ No

6. Were there distant metastases? ☐ Yes ☐ No

7. Was the diagnosis of cancer or carcinoma in-situ supported by histological, radiological or laboratory evidence and confirmed by an oncologist or pathologist? ☐ Yes ☐ No

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

   _____

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

   _____

_____ _____
Date Name and signature of doctor

_____ _____
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B. Chronic Adrenal Insufficiency (Addison's Disease)

1. Does the patient require life-long glucocorticoid? ☐ Yes ☐ No
2. Does the patient require life-long mineral corticoid replacement therapy? ☐ Yes ☐ No

3. Was the diagnosis of Chronic Adrenal Insufficiency (Addison's Disease) supported by ACTH simulation tests, insulin-induced hypoglycemia test, plasma ACTH level measurement or Plasma Renin Activity (PRA) level measurement? ☐ Yes ☐ No

   (i) If yes, please state mode of investigation done to establish the above diagnosis and attach copies of the above mentioned test result/ report.

   _____

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

   _____

4. Is the patient's condition in any way related or due to birth defects, congenital illness or abnormalities? ☐ Yes ☐ No

5. Is the patient's condition in any way related or due to sexually transmitted disease, AIDS or HIV related illness? ☐ Yes ☐ No

6. Is the patient's condition in any way related or due to alcoholism or drug abuse or any injury or illness suffered after taking intoxicating liquors or drugs? ☐ Yes ☐ No

7. What is/ are the major contributor(s) to patient's Chronic Adrenal Insufficiency?

   ❑ autoimmune adrenalitis (Addison's Disease)
   ❑ tuberculosis
   ❑ AIDS
   ❑ metastatic disease
   ❑ Others, please specify_____

_____ _____

Date Name and signature of doctor

_____ _____

Address and official stamp Qualifications

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C. Chronic Relapsing Pancreatitis

1. Which type of pancreatitis does patient has?
   ❑ Acute pancreatitis ❑ Chronic pancreatitis

2. Is the patient's condition in any way related or due to prolonged consumption of alcohol? ☐ Yes ☐ No

3. Is the patient's condition in any way related or due to gallstones? ☐ Yes ☐ No

4. Is the patient's condition in any way related or due to drug abuse or any injury or illness suffered after taking intoxicating drugs? ☐ Yes ☐ No

5. Is the patient's pancreatitis a hereditary condition? ☐ Yes ☐ No

6. Is this a recurrent pancreatitis of the patient? ☐ Yes ☐ No
   If yes, how many times of pancreatitis does patient had, including this current onset of pancreatitis? ❑ 1 time ❑ 2 times ❑ 3 times ❑ 4 times or more

7. Does patient has weight loss caused by poor absorption (malabsorption) of food? ☐ Yes ☐ No

8. Does patient's condition resulting in pancreatic dysfunction? ☐ Yes ☐ No

9. Does patient's condition require enzyme replacement therapy? ☐ Yes ☐ No
   If no, please state the type of treatment and therapy that patient is receiving or had received?

   _____

10. Was the diagnosis of Chronic Pancreatitis supported by Endoscopic Retrograde Cholangiopancreatography (ERCP) or an endoscopic ultrasound? ☐ Yes ☐ No

    (i) If yes, please state mode of investigation done to establish the above diagnosis and attach copies of the above mentioned test result/ report.

    _____

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

    _____

_____ _____
Date Name and signature of doctor

_____ _____
Address and official stamp Qualifications

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D. Dengue Haemorrhagic Fever

1. Is the patient diagnosed of Dengue Haemorrhagic Fever? ☐ Yes ☐ No If

   No, please state the type of dengue fever that patient has?

   _____

2. What is the staging of patient's dengue haemorrhagic fever according to The World Health Organisation Classification (WHO)?
   - ❑ Grade I
   - ❑ Grade II
   - ❑ Grade III
   - ❑ Grade IV

3. Does patient's Dengue Haemorrhagic Fever resulted in the following conditions:-

(i) Hypotension of less than 80 mm Hg ☐ Yes ☐ No
(ii) Narrow pulse pressure of 20mm Hg or less ☐ Yes ☐ No
(iii) Clammy skin ☐ Yes ☐ No
(iv) Oliguria ☐ Yes ☐ No
(v) Metabolic acidosis ☐ Yes ☐ No
(vi) Others, please provide details _____

_____

4) Was the diagnosis of Dengue Haemorrhagic Fever supported by serological testing of dengue? ☐ Yes ☐ No

(i) If yes, please state mode of investigation done to establish the above diagnosis and attach copies of the above mentioned test result/ report.

_____

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

_____

_____ _____
Date Name and signature of doctor

_____ _____
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E. Diabetic Complications including Diabetic Retinopathy, Diabetic Nephropathy or amputation of part of limb due to gangrene

1) Does patient has Diabetic complications which led to the following condition?

(i) Diabetic Retinopathy ☐ Yes ☐ No

(ii) Diabetic Nephropathy ☐ Yes ☐ No

(iii) Amputation of part of limb due to gangrene ☐ Yes ☐ No

2) If your answer to Question 1(i) is Yes, please answer the following questions:-

(i) Has patient undergo laser treatment? ☐ Yes ☐ No

(ii) What is the best corrected visual acuity of both eyes at present, using the Snellen Chart?

Left	
Right	

(iii) Was the diagnosis of retinopathy supported by ophthalmology with evidence of a Fluorescent Fundus Angiography report, radiological or laboratory test? ☐ Yes ☐ No

If yes, please state mode of investigation done to establish the above diagnosis and attach copies of Fluorescent Fundus Angiography report, visual acuity test, radiological, laboratory and operation reports.

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

_____

_____

3) If your answer to Question 1(ii) is Yes, please answer the following questions:

(i) What is patient's Glomerular filtration rate (eGFR) for kidney function, in milliliters/minute/1.73m^2?

_____

(ii) Does patient has ongoing proteinuria of greater than 300mg/24 hours? ☐ Yes ☐ No

If yes, please provide the proteinuria readings and the date of each reading.

_____

_____

4) If your answer to Question 1(iii) is Yes, please answer the following questions:

(i) Does patient has gangrene resulted from complication of diabetes? ☐ Yes ☐ No

If Yes, please specify which part of the limb was amputated i.e. leg, foot, toe, arm, hand or finger

_____

_____ _____

Date Name and signature of doctor

_____ _____

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Attending Physician Statement - Special Conditions

F. Osteoporosis

1) What is the bone density reading (T-score) of patient's osteoporosis, according to The World Health Organisation Classification (WHO) diagnostic guidelines?

_____

2) Please tick which category of T-score range does patient is classified to?

Category	T-Score Range	Please tick one only
Normal T-score	≥ −1.0	
Osteopenia	−2.5 < T-score < −1.0	
Osteoporosis	T-score ≤ −2.5	
Severe osteoporosis	T-score ≤ −2.5 with fragility fracture	

3) Does patient's Osteoporosis resulted in the following fractures?

i) Femur fracture ☐ Yes ☐ No
If Yes, how times does patient had femur fracture
_____

ii) Wrist fracture ☐ Yes ☐ No
If Yes, how times does patient had wrist fracture
_____

iii) Vertebrae fracture ☐ Yes ☐ No
If Yes, how times does patient had Vertebrae fracture
_____

iv) Other fracture(s), please specify which body part and give details including the number of times the fracture had occurred ☐ Yes ☐ No
_____

4) Is the patient currently able to perform the following activities of daily living (ADL) without assistance?

(i) Ability to feed oneself ☐ Yes ☐ No
(ii) Ability to wash and bathe oneself ☐ Yes ☐ No
(iii) Ability to dress, undress, secure and unfasten all garments and surgical appliances of oneself ☐ Yes ☐ No
(iv) Ability to attend to own toilet needs ☐ Yes ☐ No
(v) Ability to move from a bed to an upright chair or wheelchair & vice versa ☐ Yes ☐ No
(vi) Ability to move indoors from room to room on level surfaces ☐ Yes ☐ No

_____ _____
Date Name and signature of doctor

_____ _____
Address and official stamp Qualifications

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Attending Physician Statement - Special Conditions

G. Pheochromocytoma

1. Does patient has any of the following signs and symptoms of Pheochromocytoma?:

i)	Headaches	☐ Yes	☐ No
ii)	Palpitations	☐ Yes	☐ No
iii)	Diaphoresis	☐ Yes	☐ No
iv)	Severe hypertension	☐ Yes	☐ No
v)	Others, please specify	☐ Yes	☐ No

_____

_____

2. Does patient's tumour forms in the adrenal medulla? ☐ Yes ☐ No
3. Does patient's tumour form outside the adrenal glands (extra-adrenal)? ☐ Yes ☐ No

4. Was the diagnosis of pheochromocytoma supported by histological, radiological or laboratory evidence and confirmed by a specialist? ☐ Yes ☐ No

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

   _____

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

   _____

5. Is the patient's condition in any way related or due to inherited disorders, birth defects, congenital illness or abnormalities? ☐ Yes ☐ No

_____ _____

Date Name and signature of doctor

_____ _____

Address and official stamp Qualifications

Attending Physician Statement - Special Conditions

H. Severe Crohn's Disease

1. Does patient's Severe Crohn's Disease lead to the following complications:
   (i) Structure formation causing intestinal obstruction requiring admission to hospital ❑ Yes ❑ No
   (ii) Fistula formation between loops of bowel ❑ Yes ❑ No
   (iii) One or more bowel segment resection ❑ Yes ❑ No
   (iv) Others, please specify and provide details ❑ Yes ❑ No

   _____

   _____

2. Was the diagnosis of Crohn's Disease supported by histological, radiological or laboratory evidence and confirmed by an oncologist or pathologist? ❑ Yes ❑ No

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

   _____

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

   _____

_____ _____
Date Name and signature of doctor

_____ _____
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Attending Physician Statement - Special Conditions

I. Severe Rheumatoid Arthritis

1) Which part of patient's joints have major deformity? (please tick where applicable)

(i)	Hands	❑
(ii)	Wrists	❑
(iii)	Elbows	❑
(iv)	Spine	❑
(v)	Knees	❑
(vi)	Ankles	❑
(vii)	Feet	❑
(viii)	Others, please specify _____	

2) Does patient's medical condition has the following criteria :-

(i)	Morning stiffness	❑ Yes	❑ No
(ii)	Symmetric arthritics	❑ Yes	❑ No
(iii)	Presence of rheumatoid nodules	❑ Yes	❑ No
(iv)	Elevated titres of rheumatoid factors If yes, please provide a copy of the blood test result	❑ Yes	❑ No
(v)	Radiographic evidence of severe involvement If yes, please provide a copy of the radiological/ laboratory report	❑ Yes	❑ No

3) Was the diagnosis of rheumatoid arthritis supported by radiological or laboratory evidence and confirmed by a consultant rheumatologist? ❑ Yes ❑ No

(iii) If yes, please state mode of investigation done to establish the above diagnosis and attach copies of radiological, laboratory results and operation reports (if any).

_____

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

_____

_____ _____

Date Name and signature of doctor

_____ _____

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J. Severe Ulcerative Colitis

1) Does patient has acute severe ulcerative colitis (ASUC)? ❑ Yes ❑ No
If No, please specify the type of ulcerative colitis which patient is suffering from

_____

2) Does patient has the following complication(s) resulted from the severe ulcerative colitis?
(i) toxic megacolon ❑ Yes ❑ No
(ii) intestine ruptures ❑ Yes ❑ No
(iii) gastrointestinal perforation, or a hole in the colon ❑ Yes ❑ No
(iv) electrolyte imbalance ❑ Yes ❑ No
(v) bloody diarrhea/ stool ❑ Yes ❑ No
if yes, how many times per day (please tick one below)
❑ < 4 times (mild) ❑ 4-6 times (Moderate) ❑ > 6 times (Severe)

3) Was any of the below surgery performed or going to be performed?
(i) Colectomy ❑ Yes ❑ No
If yes, please provide the date of surgery performed or going to be performed

_____

(ii) Ileostomy ❑ Yes ❑ No
If yes, please provide the date of surgery performed or going to be performed

_____

4) Was the diagnosis of severe ulcerative colitis supported by histological, radiological or laboratory evidence and confirmed by a specialist? ❑ Yes ❑ No

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

_____

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

_____

_____ _____
Date Name and signature of doctor

_____ _____
Address and official stamp Qualifications

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Attending Physician Statement - Special Conditions

K. Wilson's Disease

1) Does patient's Wilson Disease has any of the following complication(s) due to copper deposit?

(i) Liver disease	❑ Yes	❑ No
(ii) Kidney disease	❑ Yes	❑ No
(iii) Eye disease	❑ Yes	❑ No
(iv) Neurological symptoms	❑ Yes	❑ No

If yes, please provide details

_____

_____

2) Is patient receiving medical treatment with chelating agents? ❑ Yes ❑ No

(i) If yes, please provide details on the type of medical treatment that patient is receiving or will be receiving

_____

_____

(ii) What is the duration that patient is required to take the medical treatment described in question 2(i)

_____

_____

3) Was the diagnosis of severe ulcerative colitis supported by histological, radiological or laboratory evidence and confirmed by a specialist? ❑ Yes ❑ No

(i) If yes, please state mode of investigation done to establish the above diagnosis and attach copies of radiological, laboratory results, blood tests etc.

_____

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

_____

_____ _____

Date Name and signature of doctor

_____ _____

Address and official stamp Qualifications