HSBC Life

Attending Physician Statement - Stroke

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 Stroke / Intracranial aneurysm / Arterio-venous malformation / Hydrocephalus / narrowing of cartoid artery. 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 *stroke, intracranial aneurysm, arterio-venous malformation (AVM), hydrocephalus or narrowing of cartoid artery (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)	

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

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

_____

4.4 Please describe the initial episode regarding the onset of the patient's condition as follows:

Nature of episode	
Date of initial episode	
Duration of acute symptoms	

4.5 Has the patient returned or able to return to his normal duties? ☐ Yes ☐ No
If yes, please state the date that the patient has returned or is expected to return to his normal duties.

_____

If no, please state the patient's current physical and mental limitations and the date of your assessment.

Date of assessment	Neurological limitations

4.6 Has there been any neurological deficit(s)? ☐ Yes ☐ No
If yes, please provide details

_____
_____

4.7 How long has the neurological deficits lasted since the initial episode? Please describe the neurological deficits and provide its duration in weeks.

_____
_____

4.8 Is this neurological deficit likely to be permanent? ☐ Yes ☐ No
If yes, please provide details

_____
_____

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4.9 Has there been an infarction of brain tissue, haemorrhage or embolisation from an extracranial source? ☐ Yes ☐ No

If yes, please state which of the above.

_____

4.10 Are the investigations or findings consistent with the diagnosis of new Stroke? ☐ Yes ☐ No

If yes, please provide details.

_____

4.11 Is patient's condition due to :

(a) Transient Ischaemic Attacks ☐ Yes ☐ No

(b) Brain damage caused by an accident or injury, infection, vasculitis, and inflammatory disease ☐ Yes ☐ No

(c) Vascular disease affecting the eye or optic nerve ☐ Yes ☐ No

(d) Ischaemic disorders of the vestibular system. ☐ Yes ☐ No

4.12 is an additional question for intracranial aneurysm or arterio-venous malformation (AVM)

4.12 Was an anteriogram carried out? ☐ Yes ☐ No

If yes, please provide a copy of the arteriogram report.

4.13 to 4.15 are additional questions for hydrocephalus

4.13 How was this diagnosis established? Please include a copy of diagnostic investigation report.

_____

4.14 Is the patient's condition of hydrocephalus congenital in nature? ☐ Yes ☐ No

If no, please indicate the cause of hydrocephalus.

_____

4.15 Was there any intracranial pressure giving rise to neurological deficit as a result of the hydrocephalus? ☐ Yes ☐ No

If yes, please indicate the neurological deficit(s).

_____

_____

4.16 to 4.17 are additional questions for narrowing of the carotid artery.

4.16 Was an arteriography carried out? ☐ Yes ☐ No

If yes, please provide a copy of the arteriography report.

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4.17 Please state the percentage of narrowing of the carotid artery.

_____

4.18 Was the diagnosis supported by radiological or laboratory evidence and confirmed by a or a specialist in the relevant field? ☐ Yes ☐ No

a. If yes, please state mode of investigation done to establish the above diagnosis and attach copies of MRI scan, CT scan, arteriogram, arteriography, operation notes and other diagnostic reports.

_____

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

_____

4.19 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 related brain damage? ☐ Yes ☐ No

d. Congenital anomaly or defect? ☐ Yes ☐ No

e. Attempted suicide or self-inflicted injuries? ☐ Yes ☐ No

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

Diagnosis date	
Name and address of doctor who first diagnosed the patient with the above conditions	

5. Details of treatment and surgery

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

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 is an additional question for intracranial aneurysm or arterio-venous malformation (AVM)

5.3 Was surgery carried out to correct intracranial aneurysm or arterio-venous malformation? ☐ Yes ☐ No

If yes, please provide details:

a. Indicate the nature and date of surgery under 5.2 _____

b. Was the surgery done via craniotomy? ☐ Yes ☐ No

c. Was the above surgery absolutely necessary? ☐ Yes ☐ No

5.4 to 5.5 are additional questions for hydrocephalus

5.4 Was there surgical insertion of a shunt from the ventricles of the brain? ☐ Yes ☐ No

If yes, please provide details:

a. Was the surgery done via craniotomy? ☐ Yes ☐ No

b. Was the above surgery absolutely necessary? ☐ Yes ☐ No

5.5 Is there other mode of treatment, other than shunt insertion, which could have been used to treat the patient's hydrocephalus? ☐ Yes ☐ No

If yes, please state the nature of other mode of treatment and why this treatment was not used.

_____

5.6 and 5.7 are additional questions for narrowing of the carotid artery.

5.6 Was Endarterectomy of the carotid artery carried out? ☐ Yes ☐ No

If yes, please provide details:

a. Indicate the date of Endarterectomy under 5.2 _____

b. Was the above surgery absolutely necessary? ☐ Yes ☐ No

5.7 Was the surgery performed a case of Endarterectomy of blood vessels? ☐ Yes ☐ No

5.8 Patient's response to the treatment: _____

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

If yes, please state the follow up treatment plan

_____

_____

6. Regarding the patient's medical history

6.1 Has the patient *previously* suffered from the same condition or any related illnesses such as angina, heart disease, hypertension, diabetes, hyperlipidemia or other vascular disease? ☐ 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 stroke, intracranial aneurysm, AVM, hydrocephalus or narrowing of carotid artery? ☐ 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 stroke, intracranial aneurysm, AVM, hydrocephalus or narrowing of carotid artery? ☐ Yes ☐ No
If yes, please provide details, including relationship, nature of illness, diagnosis date 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 Qualifications