

PART II - ATTENDING PHYSICIAN'S STATEMENT (STATEMENT OF CRITICAL ILLNESS)

BENIGN BRAIN TUMOUR / BRAIN SURGERY

This report is to be completed by a registered medical practitioner at the own expense of claimant.

Name of Patient			
Age		NRIC (New)	
Present Occupation		Gender	<input type="checkbox"/> Male / <input type="checkbox"/> Female

1. General Details	
a) Are you the patient's regular medical attendant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) When did your patient first consult you for this condition?	
c) Symptoms presented at that time	
d) Date of symptoms first appeared	According to patient : _____ In your opinion : _____
e) Please describe the exact details of your patient's present condition.	
f) Date last seen by you	

2. Diagnosis Details I	
a) Please give full details of the diagnosis.	
b) Date of diagnosis	
c) Name and address of doctor who established the diagnosis	
d) Was your patient informed of the diagnosis? If yes, when and by whom?	
e) Had your patient suffered any previous episodes of this condition or any other conditions leading to it or relating to it? If yes, please give details.	
f) Was your patient referred to you? If yes, please give name and address of doctor concerned.	
g) Name and address of doctor(s) who attended to your patient prior seeing you	
h) Name and address of doctor(s) concurrently treating your patient with you for this condition	
i) Was your patient referred to any other doctor(s) by yourself? Please give name and address of the doctor(s).	

3. Diagnosis Details II

<p>a) If the condition is due to an accident, please state:</p>	<p>i. Date and Time of the accident:</p> <p>Date: _____ Time: _____ am / pm</p> <p>ii. Full circumstances of the accident:</p>
<p>b) Please give details of the type of tumour.</p>	
<p>c) Exact location of the tumour in the brain.</p>	
<p>d) What was the staging of the tumour? Please enclose a copy of CT Scan or MRI Report.</p>	
<p>e) Was the brain tumour life threatening?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>f) Did the brain tumour cause damage to the brain?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

4. Did your patient undergo any surgery / procedure of the brain? If yes, please give details.

<p>a) Date of surgery / procedure</p>	
<p>b) Details of the surgery / procedure</p>	
<p>c) Name and address of the surgeon who performed the surgery / procedure on your patient.</p>	

5. Have any other investigative tests or procedures been performed? If yes, please give details and enclose a copy of the report.

<p> </p>

6. Has the patient been treated for any of the following illnesses? If yes, please provide additional information as per the table below.

	Date of diagnosis/ Onset	Name and address of Doctor(s) consulted	Dates of consultation
Hypertension			

Diabetes Mellitus			
Cardiovascular Diseases			
Other illnesses/ Injuries Please specify			

7. Please give other information which you feel would be helpful in the assessment of your patient's claim.

Note: Please enclose copies of all investigative reports including biopsy, cytology reports, CT Scans, imaging studies, laboratory evidence, surgical reports and all other relevant hospital reports that are available.

I hereby certify that I *have / have not seen the claimant's Identity Card number as stated above and that the photograph of which bears resemblance to the claimant whom I have examined.

I hereby certify that the answers above are full, complete and true.

(Signature of Doctor)
Name : _____
Qualification : _____
Date : _____

Official Hospital Stamp:

