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

STROKE

(This report must be filled up by a Neurologist)

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

Name of Patient			
Age		NRIC (New)	
Present Occupation		Gender	Male / Female

1. General Details	
a) Are you the patient's regular medical attendant?	☐ Yes ☐ 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, including exact date of episodes or conditions.	
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 to seeing you	
h) Name and address of doctor(s) who is/are treating your patient concurrently for this condition	
i) Did you refer your patient to any other doctor(s)? If yes, please provide name and address of the doctor(s).	

3. Diagnosis Details II	
a) In your professional opinion, what had caused the stroke?	
b) Did your patient suffer from any neurological sequelae? Please tick the relevant.	i. Yes, lasted more than 24 hours ☐ iii. Yes, lasted more than 6 months ☐ ii. Yes, lasted more than 3 months ☐ iv. No neurological sequelae ☐
c) Please give details of any neurological sequelae or residual defects found on patient.	
d) Are these neurological sequelae or residual defects likely to be permanent?	☐ Yes ☐ No
e) Was there any infarction of brain tissue, hemorrhage or embolization from an extra-cranial source? If yes, please give details.	☐ Yes Details: ☐ No
f) Was your patient's stroke incident / cerebral symptoms due to the following condition? If yes, please give details.	i. Transient Ischemic Attacks ☐ Yes ☐ No ii. Any Reversible Ischemic Neurological Deficit ☐ Yes ☐ No iii. Vertebrobasilar Ischemia ☐ Yes ☐ No iv. Migraine ☐ Yes ☐ No v. Trauma or Hypoxia ☐ Yes ☐ No vi. Vascular Disease affecting Eye or Optic nerve or Vestibular Functions ☐ Yes ☐ No Details : _____ _____ _____
g) Please provide us the details on the changes seen in a CT scan or MRI. Kindly enclose a certified true copy of the said report.	
h) Have any other investigative tests and procedures been performed? If yes, please give details and enclose a copy of the report.	

4. 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			

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

Note: Please enclose copies of all investigation 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: