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

AIDS DUE TO BLOOD TRANSFUSION

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	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.	
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	
a) Was the infection with Human Immunodeficiency Virus (HIV) through a blood transfusion? If yes, kindly provide reason(s) why a blood transfusion was given was attach a copy of HIV antibody test result.	☐ Yes Reason: ☐ No
b) Name and address of the institution that provided the blood transfusion and has been established to be the source of the infection.	
c) Can the abovementioned institution trace the origin of the HIV tainted blood?	☐ Yes ☐ No
d) Date of the tainted blood transfusion was given.	
e) Was your patient a haemophiliac or belongs to any of the high risk groups? Please give details if belongs to high risk groups.	☐ Haemophiliac ☐ No ☐ High risk groups, details:

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

5. 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			

6. 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: