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

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

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

Please tick (**√**) in the relevant box		Sections to be completed
	Heart Attack	1, 2, 3, 9 & 10
	Coronary Artery By-Pass Surgery & Coronary Artery Disease	1, 2, 4, 9 & 10
	Aorta Surgery	1, 2, 5, 9 & 10
	Heart Valve Replacement	1, 2, 6, 9 & 10
	Cardiomyopathy	1, 2, 7, 9 & 10
	Primary Pulmonary Arterial Hypertension	1, 2, 8, 9 & 10

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	
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. Please complete the section below if your patient was diagnosed to have Heart Attack.	
a) What are the tests done to confirm the diagnosis and test results?	
b) Please give full details of any chest pain prior to the attack.	
c) Was an ECG performed? If yes, please give date and details of the ECG changes. Please enclose a copy of the ECG results.	
d) Were cardiac enzymes measured? If yes, please provide us the details of cardiac enzymes levels. Please enclose a copy of the test result.	
e) Were Troponin T tests measured? If yes, please provide us the details of Troponin T level. Please enclose a copy of the test result.	
f) Was the condition classified as acute coronary syndrome?	☐ Yes , Details: ☐ No
g) i. Was a percutaneous procedure performed? ii. If yes, had the percutaneous procedure for Coronary Artery Disease caused a rise in cardiac biomarkers? Please give details.	i. ☐ Yes ☐ No ii. ☐ Yes , Details: ☐ No

4. Please complete the section below if your patient was diagnosed to have Coronary Artery Disease.	
a) Details of exact procedure/ surgery performed.	
b) Date of procedure/ surgery	
c) Name of surgeon who performed the procedure/surgery and hospital address	

d) If Coronary Artery By-Pass Surgery was done, i. What are the number and site of bypass grafts? ii. Was the surgery done via thoracotomy or open chest surgery?	

e) Was a coronary angiogram performed? If yes, please give date and details. Please enclose a copy of the report.	☐ Yes ☐ No Date: Details (Number, location and % of each lesions):

5. Please complete the section below if your patient had undergone Aorta Surgery.	
a) Date of procedure/ surgery	
b) Name of surgeon who performed the procedure/surgery and hospital address	
c) Was thoracotomy or laparotomy performed to repair or correct an aorta aneurysm, an obstruction or a coarctation of the aorta? If no, what was the surgery/ procedure performed?	☐ Yes ☐ No If no, surgery/ procedure performed:
d) Site of the aorta involved.	☐ Thoracic ☐ Thoracic branches ☐ Abdominal ☐ Abdominal branches

6. Please complete the section below if your patient had undergone Heart Valve Surgery/ Replacement.	
a) Date of procedure/ surgery	
b) Name of surgeon who performed the procedure/surgery and hospital address	
c) Was open-chest surgery performed to replace or repair cardiac valves? If no, what was the surgery/ procedure performed?	☐ Yes ☐ No If no, surgery/ procedure performed:
d) Was the repair performed via the following procedure?	☐ Valvotomy ☐ Intra-arterial procedure ☐ Keyhole surgery ☐ Other similar procdure? Please specify:

7. Please complete the section below if your patient had undergone Cardiomyopathy.	
a) Had any echocardiogram been done? If yes, please provide us the details and enclose a copy of the report.	☐ Yes , Details: ☐ No
b) Please confirm if your patient's condition falls within either Class III or IV of the New York Heart Association (NYHA) Classification of cardiac impairment.	

c) Was the patient's condition resulted/ related to consumption/ abuse of alcohol?	☐ Yes ☐ No

8. Please complete the section below if your patient had undergone Primary Pulmonary Arterial Hypertension.	
a) Was the disease associated with any underlying causes and conditions, or related to any congenital condition?	
b) Please confirm if your patient fall within either Class III or Class IV of the New York Heart Association (NYHA) Classification of cardiac impairment.	
c) i. Was there dyspnea and fatigue?	i. ☐ Yes ☐ No
ii. Was there increase on left atrial pressure of at least 20 units or more?	ii. ☐ Yes ☐ No
iii. Was there pulmonary resistance of at least 3 units above normal?	iii. ☐ Yes ☐ No
iv. Was there pulmonary artery pressure of at least 40mm Hg?	iv. ☐ Yes ☐ No
v. Was there pulmonary wedge pressure of at least 60mm Hg?	v. ☐ Yes ☐ No
vi. Was there right ventricular end-diastolic pressure at least 8mm Hg?	vi. ☐ Yes ☐ No
vii. Was there right ventricular hypertrophy, dilation and signs of right heart failure and decomposition?	vii. ☐ Yes ☐ No
d) Have any other investigative tests or procedures been performed? If yes, please give details and enclose a copy of the report.	

9. 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			

10. 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: