CRITICAL ILLNESS CLAIM - DOCTOR'S STATEMENT

Heart Related Conditions

Note: This form is to be completed at the Patient's expense by the Attending Physician/ Surgeon who treated the patient.

PRUDENTIAL

Patient's Personal Details

Name

Policy Number

NRIC/Old IC/Passport/Birth Cert/Others

Date of Birth

Gender ☐ Male ☐ Female

The claim is being filed for the following illness: (Please tick [✓] in the appropriate box)

	Sections to be completed
☐ Coronary Artery Disease Requiring Surgery/ By-Pass Surgery	A, B, I & J
☐ Other Serious Coronary Artery Disease	A, B, I & J
☐ Angioplasty & Other Invasive Treatments	A, B, I & J
☐ Keyhole Coronary By-Pass Surgery	A, B, I & J
☐ Enhanced External Counterpulsation Procedure	A, B, I & J
☐ Heart Attack/ Acute Myocardial Infarction	A, C, I & J
☐ Heart Valve Replacement/ Surgery	A, D, I & J

	Sections to be completed
☐ Percutaneous Heart Valve Surgery	A, D, I & J
☐ Surgery of Aorta	A, E, I & J
☐ Minimally invasive surgery to Aorta	A, E, I & J
☐ Cardiomyopathy	A, F, I & J
☐ Pericardiectomy	A, G, I & J
☐ Insertion of Pacemaker	A, H, I & J
☐ Insertion of Cardiac Defibrillator	A, H, I & J

Note: Assessment of claims and provision of benefits will be based on the Policy mentioned in this form.

SECTION A : Medical Record of the Patient

M. Are you the patient's regular/ family doctor?

☐ YES ☐ NO

If Yes, over what period do your records extend?

☐ Day ☐ Month ☐ Year

2. Date the patient first consulted you this for illness / injury.

☐ Day ☐ Month ☐ Year

3. The presenting signs and symptoms during the first consultation with you.

4. The date when the patient first noticed the presenting signs and symptoms.

☐ Day ☐ Month ☐ Year

5. In your opinion, how long have the presenting signs and symptoms lasted prior to the first consultation with you?

☐ Day ☐ Month ☐ Year

6. Please describe the full and exact diagnosis and treatment advice was given.

Diagnosis Date (DD/MM/YYYY)	Diagnosis	Treatment Advice

7. Date when the patient was informed of the diagnosis.

☐ Day ☐ Month ☐ Year

8. Which of the following factors are present? For factors which are present, please provide the date of onset.

i. Hypertension ☐ YES ☐ NO ☐ Day ☐ Month ☐ Year

ii. Diabetes Mellitus ☐ YES ☐ NO ☐ Day ☐ Month ☐ Year

iii. Hyperlipidemia ☐ YES ☐ NO ☐ Day ☐ Month ☐ Year

iv. Others, please specify

☐ Day ☐ Month ☐ Year

SECTION B

- **Coronary Artery Disease Requiring Surgery/ By-Pass Surgery**
- **Other Serious Coronary Artery Disease**
- **Angioplasty & Other Invasive Treatments**
- **Keyhole Coronary By-Pass Surgery**
- **Enhanced External Counterpulsation Procedure**

1. Please indicate the degree of narrowing (%) for each involved artery and date diagnosed.

Artery	Diagnosis Date (DD/MM/YYYY)	% of Narrowing
i. Circumflex		
ii. RCA		
iii LAD		
iv. Left Main Stem		

2. Was there any ECG changes?

☐ YES ☐ NO

If Yes, please state the changes and provide copies of ECG report displaying the changes.

3. Was coronary arteriography performed? If "Yes", please provide the date performed, name of medical center where it was performed and enclose copies of results.

☐ YES ☐ NO

If Yes, please state the changes and provide copies of ECG report displaying the changes.

4. What is the nature of treatment? Please enclose the copy of surgery report.

Treatment	If Yes, please provide the details.	Treatment Date (DD/MM/YYYY)	Details of Treatment
i. Open Heart Surgery (E.g. Coronary Bypass Graft Surgery)	☐ YES ☐ NO		Please state the approach (E.g.Thoracotomy/ Intra-arterial)
ii. Balloon Angioplasty	☐ YES ☐ NO		
iii. Coronary Atherectomy	☐ YES ☐ NO		
iv. Laser Treatment	☐ YES ☐ NO		
v. Keyhole Coronary Bypass Surgery	☐ YES ☐ NO		
vi. Transmyocardial laser revascularization	☐ YES ☐ NO		
vii. Enhanced external counterpulsation	☐ YES ☐ NO		
ix. Other forms of treatment	☐ YES ☐ NO		Please specify:

5. Is this the first time the patient has undergone any one of the above procedures?

☐ YES ☐ NO

If No, please provide the date of the first procedure and type of procedure.

First Procedure Date (DD/MM/YYYY)	Type of Procedure

Please attach certified true copies of all relevant reports. (E.g. Echocardiogram, Electrocardiogram, Coronary Angiogram reports Blood and Laboratory test results – CKMB, Troponin T, etc.)

SECTION C ▪ **Heart Attack/ Acute Myocardial Infarction**

1. Was there a history of prolonged chest pain?

☐ YES ☐ NO

If Yes, please provide the date and time of the first onset of chest pain.

☐ Day ☐ Month ☐ Year ☐ am/pm

2. What was the duration of chest pain?

☐ hours

3. Were there other symptoms?

☐ YES ☐ NO

If Yes, please elaborate.

4. Was there an elevation of cardiac biomarkers and ECG changes (I.e. CKMB and Troponin level) before any intervention?

☐ YES ☐ NO

If Yes, please provide the details of tests result of cardiac biomarkers recorded.

Please enclose all the copy of investigation reports.

If No, kindly provide the reason of cardiac biomarkers not performed.

Please attach certified true copies of all the relevant. (E.g. Echocardiogram, Electrocardiogram, Coronary Angiogram reports Blood and Laboratory test results – CKMB, Troponin T, ECG, exercise stress test, enzyme assays, isotope imaging, coronary and LV angiography, echocardiography, etc.)

SECTION D ▪ **Heart Valve Replacement/ Surgery** ▪ **Percutaneous Heart Valve Surgery**

1. Please provide full details of the diagnosis including the part of cardiac structure and type of defect that was involved.

2. Was there cardiac echocardiogram or any diagnostic test done to confirm the heart valve defects?

☐ YES ☐ NO

If Yes, please provide the details of tests result.

Please enclose all the copy of investigation reports.

If No, kindly provide the reason of cardiac echocardiogram or any diagnostic test not performed.

3. Was there surgery performed to correct the valvular defects?

☐ YES ☐ NO

If Yes, please provide the details of surgery.

Surgery Date (DD/MM/YYYY)	Type of Surgery/ Procedure	Name of Doctor & Hospital

4. What was the surgery approach?

☐ Thoracotomy
☐ Key-hole surgery
☐ Percutaneous
☐ Intra-arterial

Please attach certified true copies of all relevant reports. (E.g. Echocardiogram, Electrocardiogram, Coronary Angiogram reports Blood and Laboratory test results – CKMB, Troponin T, etc.)

SECTION E ▪ **Surgery of Aorta** ▪ **Minimally invasive surgery to Aorta**

1. Where is the exact location of the aortic lesion?

2. The surgery was performed to correct for:

☐ Aortic aneurysm
☐ Obstruction of the aorta
☐ Coarctation of the aorta
☐ Others, please specify:

3. Please provide the details of surgery.

Surgery Date (DD/MM/YYYY)	Exact Location of The Aortic Lesion	Name of Doctor & Hospital

4. What was the surgery approach?

☐ Thoracotomy
☐ Laparotomy
☐ Keyhole procedure
☐ Intra-arterial procedure
☐ Catheter based techniques
☐ Laser procedure

Please attach certified true copies of all relevant reports. (E.g. Echocardiogram, Electrocardiogram, Coronary Angiogram reports Blood and Laboratory test results – CKMB, Troponin T, etc.)

SECTION F ▪ **Cardiomyopathy**

1. What was the underlying cause of Cardiomyopathy?

☐ Coronary Artery Disease
☐ Alcohol Misuse
☐ Drug Abuse
☐ Others, please specify:

2. Please state the details of the current condition in accordance with New York Heart Association Classification of Cardiac Impairment.

☐ Class I
☐ Class II
☐ Class III
☐ Class IV

If the patient's condition falls within Class III or Class IV, kindly elaborate on the physical impairment suffered.

3. Is the patient's condition/ impairment permanent or beyond hope of recovery with current medical knowledge and technology?

☐ YES ☐ NO

If Yes, please elaborate.

4. Was there echocardiogram performed?

☐ YES ☐ NO

If Yes, what was the ejection fraction? Please enclose all the echocardiogram report.

Please attach certified true copies of all relevant reports (E.g. Echocardiogram, Electrocardiogram, Coronary Angiogram reports Blood and Laboratory test results – CKMB, Troponin T, etc.)

SECTION G ▪ **Pericardiodectomy**

1. Was there constriction of the heart?

☐ YES ☐ NO

If Yes, please provide the date of onset.

☐ Day ☐ Month ☐ Year

2. Did the patient undergone Pericardiotectomy to relieve the condition?

☐ YES ☐ NO

3. What was the surgery approach?

☐ Thoracotomy
☐ Sternotomy
☐ Others, please specify:

4. Was the surgical procedure a

i. Biopsy ☐ YES ☐ NO

ii. Aspiration of pericardial effusion ☐ YES ☐ NO

Please attach certified true copies of all relevant reports. (E.g. Echocardiogram, Electrocardiogram, Coronary Angiogram reports Blood and Laboratory test results – CKMB, Troponin T, etc.)

SECTION H ▪ **Insertion of Pacemaker** ▪ **Insertion of Cardiac Defibrillator**

1. Please provide the onset date of Cardiac Arrhythmia.

Day Month Year

2. Could the cardiac arrhythmia be treated via other methods?

☐ YES ☐ NO

If Yes, please provide details.

3. What was the non-medical treatment for the patient's cardiac arrhythmia?

i. Insertion of a temporary Cardiac Pacemaker ☐ YES ☐ NO

ii. Insertion of a temporary Cardiac Defribrillator ☐ YES ☐ NO

iii. Insertion of a permanent Cardiac Pacemaker ☐ YES ☐ NO

iv. Insertion of a permanent Cardiac Defribrillator ☐ YES ☐ NO

Please attach certified true copies of all relevant reports. (E.g. Echocardiogram, Electrocardiogram, Coronary Angiogram reports Blood and Laboratory test results – CKMB, Troponin T, etc.)

SECTION I : Others Medical Information

1. Has the patient previously suffered from this illness or any related illness or any other illnesses?

☐ YES ☐ NO

If Yes, please provide details as required below :

Date of Consultation (DD/MM/YYYY)	Illness/ Diagnosis	Types of Treatment Received/ Details of Hospitalisation	Investigation Result	Name of Doctor & Name of Hospital/ Medical or Healthcare Facilities

2. Was the patient referred to you?

☐ YES ☐ NO

If Yes, please provide details below and enclose a copy of the referral letter (if any):

Name & Address of Referral Doctor

SECTION J : **Attending Doctor's Declaration**

I hereby certify that:

☐ I am the patient's attending doctor and I have personally examined and treated the patient for the illnesses/ injuries sustained; OR

☐ I have personally perused the patient's medical records;

and that the facts as stated above are all true to the best of my knowledge and information that I have perused.

Signature : Date :

Name :

Professional Qualification :

MMC/ Registration Number :

Name & Address of Hospital/ Clinic :

Official Stamp of the Hospital/ Doctor :