MEDICAL EXAMINER'S CERTIFICATE - CONGENITAL CONDITION CLAIM

Note: This form is to be completed by the Attending Doctor at the Patient's expense

PRUDENTIAL

Patient's Personal Details

Patient's Name

Policy Number

NRIC/Old IC/Passport/Birth Cert/Other

Date of Birth

Gender ☐ Male ☐ Female

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

	Section to be completed:
☐ Cerebral Palsy	A, B & N
☐ Cleft Lip and/or Cleft Palate	A, B & N
☐ Coarctation of the Aorta	A, B & N
☐ Congenital Cataract	A, B & N
☐ Oesophageal Atresia	A, B & N
☐ Retinopathy of Prematurity	A, B & N
☐ Tracheo-oesophageal Fistula	A, B & N
☐ Atrial Septal Defect	A, C & N
☐ Ventricular Septal Defect	A, C & N
☐ Anal Atresia	A, D & N

	Section to be completed:
☐ Congenital Deafness	A, E & N
☐ Congenital Diaphragmatic Hernia	A, F & N
☐ Down's Syndrome	A, G & N
☐ Infantile Hydrocephalus	A, H & N
☐ Patent Ductus Arteriosus	A, I & N
☐ Spina Bifida	A, J & N
☐ Tetralogy of Fallot	A, K & N
☐ Transposition of the Great Vessels	A, L & N
☐ Truncus Arteriosus	A, M & N

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

1. Are you the patient's usual Medical Attendant?

☐ YES ☐ NO

2. Over what period do your records extend?

i) First consultation ☐ Day ☐ Month ☐ Year

ii) Last consultation ☐ Day ☐ Month ☐ Year

3. What were the symptoms presented when you first attended the patient? How long had the patient been experiencing the symptoms when you first saw the patient?

Symptom(s)	Duration of Symptom(s)

4. Date when the guardian / parents of patient first became aware of the condition(s).

☐ Day ☐ Month ☐ Year

5. Please describe the full and exact diagnosis.

Diagnosis	Diagnosis Date (DD/MM/YYYY)

6. Date when the guardian / parents of patient was informed of the diagnosis.

☐ Day ☐ Month ☐ Year

7. Name and practice of doctor(s) who first diagnosed the patient.

8. Please provide the dates and other details of investigations performed.

Date (DD/MM/YYYY)	Test / Laboratory / Imaging

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10. Is the diagnosis related to any of the following? (Please tick [✓] and circle the relevant option)

- ☐ Pregnancy results from fertility treatment, including in-vitro fertilisation
- ☐ Chosen to have a termination of pregnancy other than for medical reasons
- ☐ Alcohol or Substance Abuse/Addiction
- ☐ AIDS / HIV Positive
- ☐ Violation of laws / Strike / Riots

SECTION B

- **Cerebral Palsy**
- **Cleft Lip and/or Cleft Plate**
- **Coarctation of the Aorta**
- **Congenital Cataract**
- **Oesophageal Atresia**
- **Retinopathy of Prematurity**
- **Tracheo-oesophageal Fistula**

1. Was there any procedure/surgery performed for the congenital condition?

   ☐ YES ☐ NO

   If Yes, kindly provide the Date of Surgery.

   ☐ Day ☐ Month ☐ Year

2. Please specify the type of procedure/surgery done.

3. Name of surgeon and speciality.

4. ***Please enclose copies of all reports, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, etc. and any relevant hospital reports that are available.***

SECTION C

- **Atrial Septal Defect**
- **Ventricular Septal Defect**

1. Does the patient's condition warrant surgical closure for the reversal of haemodynamic abnormalities and the prevention of heart failure, paradoxic embolisation or irreversible pulmonary vascular disease?

   ☐ YES ☐ NO

2. The date on which the surgical closure is scheduled to be performed.:

   ☐ Day ☐ Month ☐ Year

3. What are the further procedures or surgery planned?

4. Please provide details of the patient's current condition.

5. ***Please enclose copies of all reports, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, etc. and any relevant hospital reports that are available.***

SECTION D

- **Anal Atresia**

1. Does the patient have high imperforated anus needing colostomy?

   ☐ YES ☐ NO

2. Was there any procedure/surgery performed for the congenital condition?

   ☐ YES ☐ NO

   If Yes, kindly provide the Date of Surgery.

   ☐ Day ☐ Month ☐ Year

3. Kindly specify the type of procedure/surgery done.

4. Name of surgeon and speciality.

5. ***Please enclose copies of all reports, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, etc. and any relevant hospital reports that are available.***

SECTION E ▪ Congenital Deafness

1. Does the patient suffer for loss of hearing of both ears present at birth?

   ☐ YES ☐ NO

2. Was there any confinement to a Hospital required directly for the treatment of the congenital deafness?

   ☐ YES ☐ NO

   If Yes, kindly provide the Date of Admission.

   ☐ Day ☐ Month ☐ Year

3. What was the treatment given?

   ☐

4. Name of doctor and speciality.

   ☐

5. ***Please enclose copies of all reports, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, etc. and any relevant hospital reports that are available.***

SECTION F ▪ Congenital Diaphragmatic Hernia

1. Was there any presence of abdominal organs in the chest cavity at birth?

   ☐ YES ☐ NO

2. Was the condition associated with pulmonary hypolasia or an underdeveloped heart?

   ☐ YES ☐ NO

3. ***Please enclose copies of all reports, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, etc. and any relevant hospital reports that are available.***

SECTION G ▪ Down's Syndrome

1. Is there an extra chromosome 21?

   ☐ YES ☐ NO

   If Yes, [illegible]

2. Does the patient exhibit as listed below:

i)	Muscular hypotonicity	☐ YES	☐ NO
ii)	Microcephaly	☐ YES	☐ NO
iii)	Brachycephaly	☐ YES	☐ NO
iv)	Flattened occiput	☐ YES	☐ NO

3. What is the nature and extent of retardation of physical and mental development?

   ☐

SECTION H ▪ Infantile Hydrocephalus

1. Does the patient have enlargement of the cerebrospinal fluid spaces resulting from obstruction of flow pathway between the secretion sites in the ventricles and absorption sites in the subarachnoid space?

   ☐ YES ☐ NO

2. Is the patient's condition serious enough to warrant the placement of a shunt?

   ☐ YES ☐ NO

3. The date on which the surgery is scheduled to be performed.

   ☐ Day ☐ Month ☐ Year

4. What are the further procedures or surgery planned?

   ☐

5. Please give details of the patient's current condition.

   ☐

6. ***Please enclose copies of all reports, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, etc. and any relevant hospital reports that are available.***

SECTION I ▪ Patent Ductus Arteriosus

1. Does the patient's ductus arteriosus fail to close spontaneously?
   ☐ YES ☐ NO
2. Did the patient start on medication treatment?
   ☐ YES ☐ NO
   If Yes, kindly provide the Date of Treatment done.
   ☐ Day ☐ Month ☐ Year
3. Does the patient's ductus arteriosus fail to close with medication?
   ☐ YES ☐ NO
4. Was there any procedure/surgery perform for the congenital condition?
   ☐ YES ☐ NO
   If Yes, kindly provide the Date of Treatment done.
   ☐ Day ☐ Month ☐ Year
5. Kindly specify the type of procedure/surgery done.
6. Name of surgeon and speciality.
7. ***Please enclose copies of all reports, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, etc. and any relevant hospital reports that are available.***

SECTION L ▪ Spina Bifida

1. Please describe the extent of the defective closure of the spinal column due to a neural tube defect?
2. Does the patient's Spinal Bifida resulting meningomyelocele or meningocele?
   ☐ YES ☐ NO
   If Yes, please specify.
3. Is the condition associated with neurological deficit?
   ☐ YES ☐ NO
   If Yes, please specify.
4. ***Please enclose copies of all reports, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, etc. and any relevant hospital reports that are available.***

SECTION M ▪ Tetralogy of Fallot

1. Does patient has any anatomic abnormality listed below:

i)	Severe or total right ventricular outflow tract obstruction	☐ YES	☐ NO
ii)	Ventricular septal defect	☐ YES	☐ NO
iii)	Dextroposition of the aorta with septal overrid	☐ YES	☐ NO
iv)	Right ventricular hypertrophy as confirmed by an echocardiogram	☐ YES	☐ NO

2. ***Please enclose copies of all reports, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, etc. and any relevant hospital reports that are available.***

SECTION L ▪ Transposition of the Great Vessels

1. Does patient have complete transposition of the aorta and pulmonary artery?
   ☐ YES ☐ NO
2. Does above condition associated with listed below:
   i) Right ventricle pump blood from the systemic veins into the aorta?
   ☐ YES ☐ NO
   ii) Left ventricle pump blood from the pulmonary veins into the pulmonary artery?
   ☐ YES ☐ NO
3. ***Please enclose copies of all reports, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, etc. and any relevant hospital reports that are available.***

SECTION M ▪ Truncus Arteriosus

1. Did the patient have large ventricular septal defect over which a large, single great vessel (truncus) arises?
   ☐ YES ☐ NO
2. ***Please enclose copies of all reports, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, etc. and any relevant hospital reports that are available.***

SECTION N : 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.

If you are not the attending doctor, please state:
The Attending Doctor's Name & Speciality:

The reason(s) for completing this document on behalf of the Attending Doctor:

Signature : Date :

Name :

Professional Qualification :

MMC/ Registration Number :

Name & Address of Hospital/ Clinic :

Official Stamp of the Doctor :

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