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.

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, K & L
☐ Other Serious Coronary Artery Disease	A, B, K & L
☐ Angioplasty & Other Invasive Treatments	A, B, K & L
☐ Keyhole Coronary By-Pass Surgery	A, B, K & L
☐ Minimally Invasive Direct Coronary Artery Bypass Grafting (MIDCAB)	A, B, K & L
☐ Enhanced External Counterpulsation Procedure	A, B, K &L
☐ Transmyocardial Laser Therapy	A, B, K & L
☐ Heart Attack/ Acute Myocardial Infarction	A, C, K & L
☐ Heart Valve Replacement/ Surgery	A, D, K & L

	Sections to be completed
☐ Percutaneous/Min Invasive Heart Valve Surgery	A, D, K & L
☐ (Minimally Invasive) Surgery of Aorta	A, E, K & L
☐ Large Asymptomatic Aortic Aneurysm/ Dissection	A, E, K & L
☐ (Hypertrophic) Cardiomyopathy	A, F, K & L
☐ Pericardiectomy (With Surgery)	A, G, K & L
☐ Insertion of Pacemaker	A, H, K & L
☐ Insertion of Cardiac Defibrillator	A, H, K & L
☐ Infective Endocarditis (Early/Late)	A, I, K & L
☐ Eisenmenger's Syndrome (Early/Late)	A, J, K & L

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 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 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

FORM ID 11601126

SECTION B

- **Coronary Artery Disease Requiring Surgery/ By-Pass Surgery**
- **Other Serious Coronary Artery Disease**
- **Angioplasty & Other Invasive Treatments**
- **Transmyocardial Laser Therapy**
- **Keyhole Coronary By-Pass Surgery**
- **Enhanced External Counterpulsation Procedure**
- **Min Invasive Direct Coronary Artery Bypass Grafting (MIDCAB)**

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

☐ YES ☐ NO

2. 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		

3. Was there any ECG changes?

☐ 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. Coronary Bypass Graft Surgery	☐ YES ☐ NO		Please select (✓) the applicable approach, ☐ Open Chest surgery (E.g. Thoracotomy, Sternotomy) ☐ Minimally invasive techniques (E.g. thoracoscopic / key-hole surgery) ☐ Others. Please specify:
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

6. Can the medical condition mentioned previously be managed via combination of medical therapy & surgery intervention (E.g. Angioplasty, By-pass surgery)?

☐ YES ☐ NO

If Yes, please provide the details on the effective combination(s) on the medications & surgical interventions.

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 *(To be completed by the cardiologist)*

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.

5. Is there any previous episode of heart attack prior to this one?

☐ YES ☐ NO

If Yes, please provide the details below,

Diagnosis Date (DD/MM/YYYY)	Final Diagnosis	Treatment(s)

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. Please select (✓) the applicable medical reason(s) of the surgery performed,

☐ To repair the valvular defect(s)

☐ To replace the damaged heart valve(s)

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 ▪ (Minimally invasive) Surgery of Aorta ▪ Large Asymptomatic Aortic Aneurysm/ Dissection

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

2. Was there any echocardiogram or other appropriate diagnostic imaging done to demonstrate the location of the aortic lesion?

☐ YES ☐ NO

If Yes, please attach the report.

3. The surgery was performed to correct for:

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

4. Please provide the details of surgery.

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

5. 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 ▪ (Hypertrophic) Cardiomyopathy *(To be completed by the cardiologist)*

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 ▪ Pericardiectomy (With Surgery)

1. Was there constriction of the heart?

☐ YES ☐ NO

If Yes, please provide the following details.

Onset Date (DD/MM/YYYY)	The underlying cause of the heart constriction

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

☐ YES ☐ NO

3. What was the surgical approach? Please select (✓) the applicable option.

☐ Thoracotomy
☐ Sternotomy
☐ Endoscopy/keyhole
☐ Others, please specify:

4. Please select (✓) the reason(s) of the surgery done,

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 ▪ Infective Endocarditis (Early / Late)

1. Please select (✓) the type of diagnosed Infective Endocarditis.

Acute ☐
Sub-acute ☐

2. Was blood culture(s) done?

☐ YES ☐ NO

If Yes, Was the blood cultures done more than once with the blood sample drawn > 12 hours apart?

☐ YES ☐ NO

If YES, please provide the following details and attach the blood culture reports.

Procedure Date (DD/MM/YYYY)	Finding(s) (Please state the name of the microorganism(s) detected)

If NO, please provide reason(s) and state how the team derived the diagnosis.

3. Was there echocardiogram or any diagnostic test done to demonstrate the lesion(s) (i.e. valvular vegetation) & the valvular incompetency(ies)?

☐ YES ☐ NO

If Yes, please provide the following details & attach the report(s)

Location of the lesion(s) **Please select (✓) the impacted heart valve(s)**	i. Tricuspid valves ☐ ii. Bicuspid (Mithral) valves ☐ iii. Aortic valves ☐ iv. Pulmonary valves ☐
Valvular incompetency(ies) / lesion **Please select (✓) the applicable option(s) on the lesion(s).**	i. Valvular stenosis ☐ ii. Valvular regurgitation ☐ iii. Valvular perforation ☐ iv. Valvular abscess/vegetation ☐

Please state the % of the stenosis or regurgitation (compared to normal heart valves) ____ %

If NO echocardiogram or any diagnostic test done, please provide the reason(s).

4. Is there any prosthetic valve implanted on the patient?

☐ YES ☐ NO

If YES, please state the reason of it being done.

Please attach all of the relevant reports (E.g. Echocardiogram, Electrocardiogram, blood culture reports & any laboratory test results, etc.)

SECTION J ▪ Eisenmenger's Syndrome (Early / Late)

1. Is there any cardiac defect(s) leading to Pulmonary Hypertension and reversal of flow / bidirectional shunt?

☐ YES ☐ NO

If YES, please provide details of the defect(s)

2. Has the patient's diagnosis resulted in any physical impairment which fulfills the New York Heart Association (NYHA) classification of Cardiac Impairment?

☐ YES ☐ NO

If YES, please select (✓) the applicable NYHA class & elaborate the following in detail: (Please refer to the next page)

New York Heart Association (NYHA) classification	Is the physical impairment permanent?	Kindly elaborate on the physical impairment suffered.
i. Class I	☐ YES ☐ NO	
ii. Class II	☐ YES ☐ NO	
iii. Class III	☐ YES ☐ NO	
iv. Class IV	☐ YES ☐ NO	

3. Is there any diagnostic test(s) to confirm the diagnosis?

☐ YES ☐ NO

If YES, please state the name of the diagnostic test and the finding(s). Also, please attach the relevant report(s) to support the diagnosis.

Please attach all of the relevant reports (E.g. Echocardiogram, Electrocardiogram, any laboratory test results, etc.)

SECTION K : 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 L : 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 :